State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

29b. Signature and title of certifia

Amir Mirza-Alikhani, M.D.

11711 Livingston Road, Fort Washington, MD 20744-5164 32. Registrar's Signature

29c. License number

Fort Washington Medical Center

29d. Date signed (Month, Day, Year)

Please Type or Print in Black'Indelible Ink. Ensure All Copies Are Legible. 1 - For State of Maryland / Department of Health and Mental Hygiene per me, 9917,07/15/2011dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 300 06 Brandt Donald Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland WMHS-RMC 9. Birthplace (State or Foreign Country) MD Social Security Number '. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🖳 M 2 🗆 F Jan 11, ^(ear)1924 Months Hours Director 218-12-5744 87 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Allegany Ellerslie MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21529 USA 10307 Mason Dixon View Street death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ian "natural", or iter Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 72 hours after 1 ☐ Yes 2 ☐ No Specify If Yes, Give WWII white Completed 3 XVidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important; If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Tire Company Tube Room Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hazel (Harris) Brandt Howard Brandt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip P.O. Box 212 Ellerslie 19a. Informant's Name/Relationship (Type, Print) MD 21529 **Donald Brandt** son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Danation 5 ☐ Other (Specify) cemetery, crematory or other place)
Sunset Memorial Park 6-8-201 MD Cumberland Signature of Funeral Service Licensee ^{22. Name and Address of Facility}eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part . Enter the discallet, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Rhysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transit MEDICAL EXAMIN and that initiated events resulting in death) Last (or as a consequence of) Physician/Medical Fracture attending physic I for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
4 Pregnant
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗆 No 1 L Yes 2 L 9 Dunknown the hed Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detact. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes _2 🗹 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: မ 1 Natient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Yea May 2011 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Unknown_M work? 1 ☐ Yes 2**X**☐ No Natural 5 Pending Subject fell Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10307 Mason Dixon View St., Ellerslie, MD 21529 Homicide determined Home Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier □ Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated as □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) de use of death (Item 23a) (Type, Print) 30. Name and address of person who completed RD LAM.D. 12501 WILLOWBROOK MANOHA CHENCHUGAL Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 0 2011 Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 23, hristman. 2011 elen M 9:45 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles County Nursing & Rehab Charles LaPlata Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Months Hours Min Washington DC 579 30 2251 Director Sept Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location at 10d. Inside City Limits Director notified 28a-f Maryland Prince George Clinton 1 Yes 2 X No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral with 6410 Springbrook Lane 20735 United States . Page 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene.
tant, If item 27 is marked other than "natural", or items luny or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 21/21/No Specify Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Pfeil Pfeil Annie Marie Cassell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Schuhart (Daughter) Department of Health Important: If item 27 any injury or other tr 7880 King Arthur Court, White Plains, MD 20695 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory May 25, 2011 Clinton, MD Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 10 Ye Ph_sician/ disease or condition Medical resulting in death) nce **Q**f): Examiner Secuentially list conditions Completed by Physician/Medical Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at Id be detached for 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 1 TYes 3 Probably 4 Unknown cate has been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy meone 2 X No 1 Yes Be 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 2 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred Natural Accident Duicide iniury 5 Pending 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [To the I within 2 To the I only one) 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) 7119 05124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Josin Vazhappilly mp. 2007 Tidewater + Drive IA, Annapolis MD, 21401 Josiin Vazhappilly mp

Registrar

State

MAY 26

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $\supseteq \emptyset$ For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 201 0:22 p.M Medical Patricia Carroll 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mary's Mary's Hospital eonardtown 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 1 🗆 M 2 🛛 F Days Hours Min 63 Yrs Director 579-64-2897 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once. 10a. State 10d. Inside City Limits Director 1 X Yes 2 No Maryland St. Mary' Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21412 Great Mills Road United States 20653 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 X Divorced Specify: Completed White 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Retail Sales Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mahlon A. Carroll <u>Doris Jackson</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadette Snead/Sister 23491 Kingston Creek Road, California, MD 20619 20a. Method of Disposition
1 Å Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Episcopal Cem 06/03/2011 St. Mary's City, MD Signatura of Lineral Service Licensee
Edward N. Brinsfield Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Sullen Onset and Death Physician/ disease or condition (n) me Medical resulting in death) Due to (or as a consequence of) Examiner וטשבוטישונשי Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last isbetes and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) 4 🔲 Pregnanτa 9 🔲 Unknown page 2 should be detached 1 ☐ Yes ∠ 9 ☐ Unknow signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury 1X Natural 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State egistrar's Signature 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Harwood Mandrin Chesapeake Hospice House 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In vrs. last birthday Funeral Hours Texas Days 09/2971924 86 Yrs 711-14-7860 Director Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director Examiner must be notified 1 Yes 2 X No 28a-f Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 23a United States 21037 329 Colony Point Place "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 24 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. þ Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🛣 No Specify: White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Auditor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 01a Tabor ဥ Clint Zimmerman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 Colony Point Place, Edgewater, Maryland 21037 19a. Informant's Name/Relationship (Type, Print) James R. Cumberpatch/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State Edgewater, Maryland 05/25/2011 4 Donation 5 Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility George P. Kalas Funeral Home 2<u>973 Solomons Island</u> Road, Edgewater, MD 21037 Part 1. Fuer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Enysician/ disease or condition resulting in death) Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) and I-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician a the for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 mont Month Day Year Other (specify) Pregnant at time of death 4 Pregnant : 9 Unknown ate has been signed by the apage 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 4 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Certificate: To Be examiner? Hospital 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner eath 28b. Time of 28d. Describe how injury occurred iniury 5 Pending atural 2 🗌 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Descripting Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 0 tuse of death (Item 23a) Type, Print) DEFENSE HWY, ANDAPOLES, HD. 21401

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

-Too-

TAP

Registrar's Signatur

445

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Maryland / Department of Health and Mental Hygiene State Amended #8perFH FCHD KS 5/24/11 Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month A M 11:12 Russell Elwood Densock May 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3352 Chiswick Court, 57-1H Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Funeral Hours Director 89 Yrs July 212-18-1839 Usual Residence of Decedent July 6. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director 28a-f 1 🗋 Yes 2 ា No Maryland Montgomery Silver Spring 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3352 Chiswick Court, 57-1H 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1942—
If Yes, Give 14. Race - American Indian. Black White etc. Completed by "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify: 3 Widowed 4 Divorced Year or Dates 1946 White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 12 Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 127 is marked o ပ Daniel L. Densock Cora Bell Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana L. Yavetz/Daughter 14604 Jaystone Drive, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important; If it any injury or o cemetery, crematory or other place)
Rocky Gap
Veterans Cemetery May 26,2011 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Flintstone, Maryland Name and Address of Facility Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, MD 20872 21. Signature of Funeral Service Lice 23a. Part 1. Enter The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiac arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** oronary arte Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events physician and the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical law requires that the death certificate be 38 attending IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Yes 2 No signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by congestive heart failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No I or Attending Physician: The I after death.
Director: After this certificate h 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

Records, P.O. Box 68760

Division of Vital

leted cause of death (Item 23a) (Type, Print)

NO

Shapiro

*ከ 35*336

10810 Connecticut Ave. Kensington MD 20895

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month p^M Kristy Sue Danfelt May 25 20113:55 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington 135 West Potomac Street Williamsport If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕶 F Days Months Hours Min. 7/26/1956 Maryland 220-64-6518 **Director** 54 Usual Residence of Decedent of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Yes 2 No MD Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 137 West Potomac Street 21795 U.S.A. hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Nes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Dietary Cook Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Health and Mental H item 27 is marked of John Miller Betty Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David M. Danfelt / Spouse 137 West Potomac St., Williamsport, Maryland 21795 or other Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o Page 1 cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park 5/31/2011 Williamsport, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel SM K 1601 Pennsylvania Ave., Hagerstown, 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one caus Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ 20 Years Medical resulting in death) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last ng physician and as the burial-trans Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Day Month Year be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? 1 🗌 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred 1 XNatural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month, Day, Year) and, D 00 68995 28 201 Yong Tang, MD nd address of person who completed cause of death (Item 23a) (Type, Print) 11300Pal ct Manyland

State

Registrar

31. Date filed (Month, Day, Year)

MAY 3 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 5/22/2011 Edward E. Dobrick, Jr. 1737 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number **Funeral** Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) 1**X** M 2 □ F Months Days Hours Director 977/1924 86 200-12-0262 Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis 1 Yes XX No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 931 Edgewood Rd. Apt. 21403 USA 206 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1XXYes 2 No WWII Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 should be filed within 72 hours afti and Mental Hygiene. is marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2000 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Engineer Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward E. Dobrick, SR. Helen Marks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Daughter Diane Breinig Sunwood Terrace Annapolis, MD 21403 1387 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) West Moreland County | 5/26/2011 Greensburg, PA Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Ent. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam death certificate be executed Cause (Disease or iinjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical phy: the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No Yes 2 Be 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 🗆 Yes 2 Accident
3 Suicide Investigation 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

104 State 29b. Signature and litle of

31. Date filed (Month, Day, Year

2 4 2011

30. Name and

Box 68760

P.O.

Records,

Division of Vital

cause of death (Item 23a) (Type, Print

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lawrence O. Dulin Physician/ 20 2011 10:37 PM May Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heartland House Grasonville Queen Anne's . Age (In yrs. last birthday **Funeral** 219–26–8980 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Months 1 X M 2 D F Min. Hours Year) 73 Maryland Director 19 1937 Nov Usual Residence of Decedent shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Directo Maryland Queen Anne's Chester 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 109 Harbour Sound Drive 21619 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Yes, Give 10 Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2X No Specify. White "natural" 3 🗆 Widowed 4 🗆 Divorced Year or Dates. 1956-59 Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Medevac Pilot MD State Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilbur R. Dulin Anna L. Krieger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine P. Garringer/wife 109 Harbour Sound Drive Chester, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ö 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Department of Important: If any injury or Baltimore Crematory 5/25/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Theral Sa 22. Name and Address of Facility John M. Taylor Funeral Home 0 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ HEMAN GOPERICYTOMA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 mg Day Pregnant at time of death the Unknown 9 Unknow P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy certificate 1 Yes 2 No 1 Yes 2 Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Assisted Living 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this After this funeral of 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No thours after death.

uneral Director Afted filled in by tee fur Accident Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral Completed filled Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat 29c. License number 000 6 4852 DN COLOGY 30. Name and address son who completed cause of death (Item 23a) (Type, Print) 3+1 MEDICAL ANNA POUT, M RAVIN PARKWAY. WAYSON 201. GBRG DR-2001 State

Registrar

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	4	 Facility Name (if not institution 430 Imla Street 	on, give street	and number)		4b. City, T Baltin		ation of Deat	n	4c. County of	of Death	
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Lant: If item 27 is marked other than "ostural", or items 23s or 28s-f sho or other traumatic event, the Medical Framiner must be notified at once.	ted to	15. Decedent's Education (Spe Elementary/Secondary (0-12)	cify only high		duri	edent's Usual ng most of wor				16b. Kind of Bu		
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying I			nowledge, death							
To the within To the compl	2		and m	anner stated.	nation and/or inve		. License n		at the time, dat	29d. Date sign		
	2	29b. Signature and title of certif	ÇI			29	O.C.M.I			June 5, 20		, Day, 1661)
Sy	-	30. Name and address of person	who complet	ed cause of dea	ath (Item 23a)		20.20					
P		Donna M. Vincenti, N			l Examiner	900 W. Ba	timore S	treet, Balti	more, MD 2	1223		
Sta		31. Date filed (Month, Day, Year	6	32. Registrar's	Signature					·		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2155 M Tarrell Aanes Lorraine Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Mary's Leonardtown If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Funeral Hours 1 □ M 2 🖾 F Months Days Min (Month, Day, Year) 77 Yrs. Director 217-54-3085 January 29, Maryland Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location at 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 X No St. Mary's Maryland Avenue ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 37790 Paul Ellis Road 20609 items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or 2 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: Completed 3 Widowed 4 Divorced White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Board of Education Cook permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, ? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Leonard Hall Myrtle Virginia Knott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Charles Henry Farrell / Hus</u>band 37790 Paul Ellis Road, Avenue, MD 20609 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State June 6, 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery 2011 Bushwood, Maryland Signature of Funeral Service License Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, MD 20650 Approximate Interval Between Onset and Death Physician/ Week Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examir monus slcian and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical CHE Division of Vital Records, P.O. Box 68760 LORDAING FARE es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death signed by the at Id be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 2 No 3 □ Probably 4 □ Unknown 1 Tyes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? Yes 2 No Bres cynces HIO After this certificate 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 4 NES Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 5 Pending iniury 1 Natural Accident Investigation within 24 hours after death

To the Funeral Director: A

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D 622 3 11 6 10 pme 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) uresh 25500 Point Lookart Road, Leonardtown, MD 20650 a T 32. Registrar's Signature State JUN 0 3 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Janet Fiddler a M Mildred Medical 8:00 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 F Months Days Min. Hours (Month, Day, Year) **Director** 214-34**-**0680 193 West Virginia March Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1X Yes 2 No MD Washington <u>Hagerstown</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 442 Ridge Ave. 21740 U.S.A 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force 1 Yes 2 No Black, White, etc. ò by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates. White th and Mental Hygiene.
27 is marked other than "natul traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lonnie Fiddler Johnson Mamie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Daughter Brenda Baker / 308 East Magnolia, Hagerstown, MD 21742 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 0 Department of Important: If any injury or once, 4 Donation 5 Other (Specify) Rest Haven Cemetery 5/26/2011 Hagerstown, Maryland 21. Signature of Funeral Se Nice Lic 22. Name and Address of Facility Rest Haven Funeral Chapel Pennsylvania Ave., Hagerstown, 23a, Part 1. Enter the dise Part 1. Enter the dise is a recomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ HINWMIG Medical resulting in death) Examiner non Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ng physician and as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: for use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year signed by the al 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy or Attending Physician: The performed certificate 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death Certificate: Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1. Natural iniury Division 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as estated. (Check date and plant, and dive to the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2000 Z D069946 May 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11116 Medical Campus Road, Suite 1153, Hagerstown, Md. 21742 State egistrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2694 00 PM 2011 Helen Lorraine Glesner Ma 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Williamsport 16718 Virginia Avenue Washington If Under If Under 8. Date of Birth 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign 1 M 2 XF Days (Month, Day, Year) Oct. 2, 1927 Months Hours 212-24-2802 83 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 💢 No Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16718 Virginia Avenue 21795 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify. 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Produce Sales Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Augustus Burger Hilda Lucille Randall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie Boyer - Daughter 16718 Virginia Avenue Williamsport, Maryland 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Rose Hill Cemetery June 1,2011 Hagerstown, Maryland 4 Donation 5 Other (So 21. Signature of Funer at 1997 Osbarne AFunerally Home, P.A. 425 S. Conococheague St.Williamsport,MD 21795 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) (ave 411. Due to (or as a consequence of):

Physician/ Medical Examiner Examine

Physician/

Examiner

Funeral

Director

show

ral", or items 23a or 28a-f shov Examiner must be notified at

"natural", or

permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the and injury or other traumatic.

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72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Medical

10a. State

Director

Funeral

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Completed

Be

physician and s the burial-transit The law requires that the death certificate be executed atten for u ed by the a has To the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760

Physician/Medical by within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page Be Certificate: To

Completed

Medical

29b. Signature and title of certifier

Michael

Sequentially list conditions,	h											
if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):											
that initiated events resulting in death) Last	C. Due to (or as a consequence of):											
	d											
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year									
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?									
		24a. Was an autopsy performed?										
25. Was case referred to medical examiner?	26. Place of Death (Check	only one)										
1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)											
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work? n	8d. Describe how inju	iry occurred									
3 Suicide 6 Could not to determined		nd Number or Rural Route Number, e)										
	rsician: To the best of my knowledge, death occured at the time, date and place, and liner: On the basis of examination and/or investigation, in my opinion, death occurred at											

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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edical Cumpus

Registrar

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11110

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5 per FD State of Maryland / Department of Health and Mental Hygiene 🤈 AACO Health Depotsor 5-24-11 KAH State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0.5 Physician/ Sobert GROLLMAN 8:28PM 0 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y Aug. 26, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Year) 1936 **1X** M 2 □ F Months Days Hours Min. 214-44-6961 Maryland **Director** Aug. Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Anne Arundel Annapolis 1XXYes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? U.S.A. ò 10f. Zip Code ed other than "natural", or items 23a o event, the Medical Examiner must be 1293 Virginia Street Funeral 21401 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Year or Dates.1954-58 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Supervisor Post Office should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Zorn Grollman ပ Mary Kovalich 19a. Informant's Name/Relationship (Type, Print)
Doris Grollman/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1293 Virginia Street Annapolis, Maryland 21401 1 and 2 s if Health item 27 i or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date metery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore Crematory 5/23/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ OROMANY disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last and -tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year signed by the a ld be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ➤ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 2 🗆 No Yes 2 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 🔀 Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) ▶ at 05, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -9+ Medical Packway, Annapolis, MD 21401 -FAROOD 200 HAWAJA-A State MAY23 Registrar

11-03998 James Harris Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ames Harris		State of Maryland / Department of Health and Men		eg. No. 2011	18516							
Physici Medical Exami		1 1. Decedent's Name (First, Middle, Last)	2. Date of Dea	th Day Year	3. Time of Death 1829 hrs							
- 22.7		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 28 Sumac Road Glen Burnie		4c. County of Death								
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Und		rth(MM/DD/YYYY) 9. Birt								
Director		215-98-3451 153 M 2 F 36 Yrs. Months Days Hours	Min. Januar		untry) GA							
w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits							
Aaryland 28a-f show	Director	MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code		0g. Citizen of What Cour	1 X Yes 2 No							
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nours after	ed by	or Dates:	kind of work done	16b. Kind of Business/li	ndustry							
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21215-0036 uld be filed within 72 Mental Hygienc. marked other than " c event, the Medical	Be Col		rs Name (First, Middle, I ine M. Jone									
MD 2121 d 2 should be fi th and Mental a 27 is marked numatic event,	ToE	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State										
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and In Important: If item 27 is us injury or other traumatic		Marvin Jones / Uncle 4628 Lacy Ave, Suitland 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or crematory or other place)										
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify: Fort Lincoln Cemetery	June 4,2011	Brentwood,	Maryland							
Ba permii Depar Impo		21. Signature of Funeral Service Idensee 22. Name and Address of Facility 23. Signature of Funeral Service Idensee 24. Signature of Funeral Service Idensee 25. Name and Address of Facility 55.38 Mar1boro P	ike, Forest	tville, MD 2								
Physician /Medical		22a/Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a failure. List only one cause on each line. Multiple drug toxicity involving limmediate Cause (Final disease and doxylamine complicating biven	ardiac or respiratory arr ing chlordi tricular ca	est, shock, or heart azepoxide	Approximate Interval Between Onset and Death							
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OX 6876(eath certificate attending phys for use as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic	c pregnancy	23d. Date of delivery Month D	ay Year							
Box (e death ce the attence for use	hysici	4 Pregnant at time of death 5 Other (Specify) 9 Unknown										
P.O. res that the signed by 1 be detache	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to											
Division of Vital Records, P.O. Box 68760, within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi	Completed		24a. Was autop perfo	psy prior to c med? death?	opsy findings available ompletion of cause of							
Vital Reoviniem: The his certificate director, page	å	25. Was case referred to medical 26. Place of Death examiner?		Residence 6 ✓ Other	Coope							
ng Phya After thi	ñ: آ	. 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work	? 28d. Describe	how injury occurred	Scene							
Division tal or Attendi rs after death.	icatio	Natural 2 X Accident Solution Solution Natural 2 X Accident Solution So	c. 28f Location (5	took drugs	al Route Number, City							
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Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ह्न	Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	ace, and due to the caus courred at the time, date	se(s) and manner as state and place, and due to the	ed. e cause(s)							
T 2 2 3	Medic	29b. Signature and title of certifier 29c. License number O. C. M.E.		29d, Date signed (Mon	th, Day, Year)							
0		30. Name and address of person who completed cause of death (Item 23a)										
1/2	nto.	Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, B	altimore, MD 2122	23								
St Regist	ate											

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 25, 2011 9:11 A Martha Easton Hampton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Calvert Prince Frederick Calvert Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Ap/Y11 D2/4 Year 930 Kefitticky Director 404-34-7790 81 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Welcome Maryland Charles 1 🗆 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20693 United States 8300 Blossom Point RD. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. White δ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed withIn 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) At Home 12 Homemaker Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event ones. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Laura Gray Dester Easton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Coleman Hapmton/Son 8300 Blossom Point Rd., Welcome, MD 20693 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State July 6, Arlington National Cem. Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., M00817 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cevebrougsvular disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury Due to or as a consequence of attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day 2 No After this certificate has been signed by the funeral director, page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 22 No 1 Yes 2 No Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifics 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 27 No 1 🗌 Yes မ 1 ☐ Inpatient 2章 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1- Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 1🖅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only one) 29b. Signature and title of certifie 29c. License number

peme

State Registrar

Dr. David Tardio, 110 Hospital Rd., Suite 310, Prince Frederick MD 20678
31. Date filed (Month, Day, Year)
32. Projector's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Rigistrar's Signature

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Registrar

30. Name and address of person

who i

DHMH 17 Rev 1/2001

2

3+1VA

368

null street Hagsbern 21740

ompleted cause of death (Item 23a) (Type, Print)

HAM egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Henry Paulette D 2011 РМ 6:15 5 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Suburban Hospital Montgomery 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) 2b. 3, 1921 1 M 2 Z F Hours Min. 90 France 166-38-4591 Director Feb. Usual Residence of Decedent show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Washington, D.C. 1 X Yes 2 No DC none 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20015 USA N.W. #244 6200 Oregon Ave., 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Attorney marked other Be permit. Page 1 and 2 should be filed beardment of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Aime Daumen Therese Crest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6200 Oregon Ave., N.W.#244 Washington, D.C.20015 Richard H. Henry/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State June 7, Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signatur Foneral Avice Cens e M01315 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, DC 20007 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final - h, sician/ Ischemic Colitis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or imjury that initiated events and resulting in death) Last Due to (or as a consequence of) physician a s the burial-Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) 2 X No his certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Acute Renal Failure, Atrial Fibrillation 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) _2 🗶 No 1 Yes ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 🔲 Yes Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one chitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 6, 2011 D0060117 MD

State

DHMH 17 Rev 7/2009

ANTY, PAULOTED,

Registrar

8600 Old Georgetown Rd. Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

Eric Park, MD
31. Date filed (Month, Day, Year)

JUN 1 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 21.49 pm Johnson GOUGH MARGIE 19 MARY 2011 05 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST MARY ST MARY'S HOSPITAL LEONARDTONA LEONARDTOWN If Under 1 Year If Under 2 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Hours Min. MAYOnth, Day, 17925 MARYLAND 213-22-0825 86 Director Usual Residence of Decedent show 10d, Inside City Limits 10a, State 10b. County 10c. City. Town or Location event, the Medical Examiner must be notified at Director or 28a-f 1
▼ Yes 2 □ No CHARLES MARYLAND POMFRET 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8245 WARREN DRIVE 20675 UNITED STATES items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ð "natural", or 3altimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 👿 No Specify: Specify: BLACK 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a Decedent's Usual Occupation 16b, Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmatic. College (1-4 or 5+) Elementary/Seconday (0-12) SELF-EMPLOYED RETAIL 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, EDWARD WHALEN MARY WENDY BENNETT WHALEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 RIVERMONT DRIVE, WALDORF, MARYLAND DORIS E. JOHNSON / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State CHARLES MEMORIAL GARDENS 5/26/11 LEONARDTOWN, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) LYDIA C. THORNTON JOHNSON MOO583 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 I.IVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ventercular tuchterdia disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate s a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events burnamia and -tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Month Day Pregnant at time of death Unknown 9 Unknown JOHNSON, MARY MARGIE 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MR#: 00283485 0007459948 Completed by to thrive 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 2 Yes 26. Place of Death (Check only one) Be 2 🖳 No Hospital Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 Yes 2 No 1 Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital or afte within 24 hours a hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number Karmin 2011 D68782 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) her non dtown vemwe' 31. Date filed (Month Pay, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Richard Wayne JOHNSTON 10:25 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Sept 7 Year 1924 1 X M 2 - F Hours 382-18-4273 86 Michigan Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Hagerstown Maryland Washington XX Yes 2 No 10f. Zip Code 21740 10g. Citizen of What Country? 10e. Street and Number 1008 Brinker Drive Apt 102 items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 铽 Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 2 should be filed within 72 hours after deat th and Mental Hygiene. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner I Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) management truck mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 1008 Brinker Drive Apt 102, Hagerstown, Maryland 740 Anita Johnston - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hagerstown Crematory May 2301 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia, shock, or heart failure. List only one cause on ach line Immediate Cause (Final et ur or i Physician/ disease or condition resulting in death) Medical Due to for as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pathed for use as f as t IF FEMALE: outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown detached been signed by should be detack Part II. **Other significant conditions** contributing to death but not resulting in the underlyj**n**g cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ 21 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performed page, After this certificate 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, ဂ္ Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending (Month, Day, Year, Natural work death. М 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier SHIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		Registrar 1. Decedent's Name	e (First, Middle, La	est)			erunca	le or L	Jeani	2. Date of D	Reg. N	lo.	11	3. Tin	ne of Death
Physicia Medic		James Oscar Johnson May 17 ^{Pay} 201 ^{eq}												4:2	
Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 9330 Dubarry Ave. 4c. County of Death Prince												je's	
Funeral Director		5. Social Security N 578–24–70	umber 6.5		Age (In yrs. la	ast birthda Yrs	Months	er 1 Year Days	If Under 24 Hrs Hours Min		irth ay Year	1926	g. Birt Cor	hplace (Sta	ate or Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (me (First, Middle			,				
d Men marke	۲	Francis DeSales Johnson Lucy Cecilia Mattingly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,											0 (1)		
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Physician/		Immediate Cause (disease or condition	(Final	Gas	troen	tera	1 b	lee	ling					Onset a	and Death
Medical Examiner		resulting in death)	ſ	Due to (or a	s a consequence of):									3	yrs
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Medical	(Check 2	🔲 Medical Exan	ysician: To the best niner: On the basis o	of my knowl	ledge, dea	ath occured a	at the time	, date and place, on, death occurred	and due to the of at the time, date	ause(s)	and manner ce, and due	as sta	ited. cause(s) an	d manner stated.
To the within To the compl	Σ	only one) 3 29b. Signature and		rse Practioner: To the	LW () knowledg	ge, death occ	c. License	e number	2/3	29d. E	ate signed	(Month	n, Day, Year	n)
,		30 Name and addi-	ass of para	completed cause of	death /Ita-	230\ /Tir-	pe Print) -	UC	100	0000	120	211	10		
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Stat Registra		31. Date filed (Mont	h, Day, Year) MAY 23	2011 32. Reg	trar's Signat	ture f.	par	1	, date and place, on, death occurred e time, date and pe e number O S S S						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of M State Amend Item 25 per me	g916,	d / Depa ,06/20 ,e/	rtment of H /2011dhb tificate of L	lealth and I Death	vlental Hyg	giene Reg. No		18523	
	Physicia		1. Decedent's Name (First, Middle, Last) Mildred Ruth Keefer					2. Date of Dea Month	ath 2 ^{Pgy} ,	2041	3. Time of Death 05:15 Am	
	Medic Examin		4a. Facility Name (if not institution, give street and number) BelAir Health and Rehabilitation		4c. County of Death Harrford							
	Funeral Director		5. Social Security Number 6. Sex 7. Ag 1 □ M 2 ♣ F 7. Ag	ge (In yrs. las		Pel Ai	If Under 24 Hrs. Hours Min.	8. Date of Birth June 14			place (State or Foreign	
	Aaryland 8a-f show tified at	rector	Usual Residence of Decedent 10a. State 10b. County Maryland Harford		, Town or Loc sville	ation					10d. Inside City Limits	
	with the h 23a or 2 ust be no	Funeral Director	10e. Street and Number 213 St. Marys Road			10f. Zip Code 21132			10g. Citizen U.S.A.	Citizen of What Country?		
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Status 1f Yes, Give Year or Dates.	Ever in U.S.		/as Decedent of His Yes, specify Cubar ☐ Yes 2 Hoo	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - American Indian, Black, White, etc. <i>White</i>		
Baltimore, Maryland 21215-0036	vithin 72 hou giene. er than "natu the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or	5+)	16a. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired) Homemaker			sing		6b. Kind of Business Industry Own Hame		
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more	Page 1 an nent of He ant: If iten ıry or oth		20a. Method of Disposition 1 ⅔ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Pla More	ace of Dispos Pared 149 Cene	sition (Name of the Part Lery	May 3	Date 011		on - City or T		
Balt	permit. Departr Import any inji	. (5	21. Signature of Funeral Service Licensee	M0154	13) 22 13) 3	Name and Addres Vains Funera Newport Dr	l'Chapel & ive, Fores	Cremetic t Hill, M	n Servio aryland	21050 B	el Air	
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Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Ves 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)			23d.	23d. Date of delivery Month Day Year		
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sion c	Attending death. ctor: After y the fune	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	? Yes 2 No	28d. Describe how injury occurred No 28f. Location (Street and Number or Rural Route Number,							
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	Nith Con		29b. Signature and title of certifier	7		29c. License D56545			29d. Date sig May 27		Day, Year)	
			30. Name and address of person who completed cause of Shilpi Khosla 615 W. MacPhail	death (Item :			Morestand	21014		<u> </u>		
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State		St	tate of M	arylan					and N	lental Hy		20	1 1	19521
		Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death											and the second	3. Time of Death		
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nd 2 s ealth e m 27 i		Robert J.		SR.	Father					ns I	sland	RD.				20711
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp xx Burial 2	Cremation		oval from State		Place of Disp emetery, cre	osition (Na matory or	me of other plac			Date				Town, State
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Deperting any i		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Ho 12 Ridgely Ave. Annapolis, Md 2140											ноте 401	2, P.A.		
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uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflitated events Due to (or as a consequence of): EVD 5T9GE CVEY 015E95E														
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Medical	(Check 2	☐ Medical	Examiner: C	n the basis of	examinatio	n and/or inve	stigation, in	my opinic	on, death o	occurred a	t the time, date to the control of the time, date to the control of the control o	and plac	ce, and due	e to the	cause(s) and manner stated.
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 2011 June 3, 12:48 Am Moretha C. Lancaster Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth Age (In yrs, last birthday) **Funeral** 1 □ M 2 🗗 Days Min. Feb. 4. Director 92 <u>577-6</u>0-5441 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 X Yes 2 No Washington DC 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 239 Funeral 20002 United States 1717 Lyman Place NE · items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married "natural", or Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) US Bureau of permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Engraving and Printing 12th Forewoman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nicy Edwards James Carrington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington, DC 604 Buchanan Street NE Charlynn B. Lancaster-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ABurial 2 Cremation 3 Removal from State June 4 ☐ Donation 5 ☐ Other (Specify) 2011 Washington, DC 01ivet 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service Lice is tohu 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysiciani RESPIRATORY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death ed by the detached g 🗌 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed the should be detected 23e. Did tobacco use contribute to the cause of death? þ ANEMIA 1 Yes 2 No 3 Probably 4 nknown Division of Vital Records, Completed REWAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed 1 ☐ Yes 2 🗷 No certificate Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: မ 1 ☐ Inpatient 2' ☐ ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Secretifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JUNE 3,2011 D40324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Takoma Park, Maryland Terry Jodrie 7600 Carroll Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2011 JUN O Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 21 MAY ŽÖ11 15:12 PM HELEN ELIZABETH PELHAM LAW Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES CLINTON SOUTHERN MARYLAND HOSPITAL CENTER 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. AUGUST 27, 1931 VIRGINIA 1 ☐ M 2 🙀 F Director 577-42-2645 79 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director "natural", or items 23a or 28a-f sl edical Examiner must be notified 1 X Yes 2 No DISTRICT HEIGHTS MARYLAND | PRINCE GEORGES 10g. Citizen of What Country? 10e. Street and Number Funeral UNITED STATES 20747 1860 ADDISON ROAD SOUTH within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Specify: BLACK 3 X Widowed 4 Divorced Completed Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER HOUSEWIFE 9TH GRADE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) INEZ CATHERINE WEAVER PELHAM DOUGLAS PELHAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3520 WOOD CREEK DRIVE, SUITLAND, MARYLAND 20746 RUTH A. WILLIAMS / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place, LINCOLN MEMORIAL CEM. JUNE 1,2011 SUITLAND, MARYLAND ure of Funeral Service licenses

LYDIA C. THORNTON JO. THORNTON FUNERAL HOME, P.A THORNTON JOHNSON MO0583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No this certificate Yes 2 X N within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 1 Yes 2 No 1 Inpatient 2 XER/Outpatient 3 IDOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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State Registrar 29b. Signature and title of certifie

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 17 Physician/ 2011 8:33 P M Anna Marie Laudwein Medical 4a. Facility Name (if not institution, give street and number) 4b City Town, or Location of Death 4c. County of Death Examiner 1708 Grandad's Lane Silver Spring Montgomery Social Security Number If Under Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Month, Day Year 1921 1 🗆 M 2 🐷 F Months Hours Min 578-34-5926 Maryla<u>nd</u> 90 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ■ No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? event, the Medical Examiner must be Funeral 23a 25901 Ridge Manor Drive 20872 items ? 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. è ģ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates White 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 4 Homemaker and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked John R. Urquhart Emma Cecelia Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Laudwein, Son 1708 Grandad's Lane, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
All Souls
Cemetery ■ Burial 2 ☐ Cremation 3 ☐ Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) May 21,2011 Germantown, Maryland Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, MD 20872 Signature of Funeral Fervice I 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Months Immediate Cause (Final Ph_sician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter oncernying Cause (Disease or linjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown the P.O. þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate | 1 ☐ Yes 2 ☐ No Yes 2 No or Attending Physician; filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🖷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 € Other (Specify) Sons Home this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of : After t Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? within 24 hours after death To the Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the 3

10 State 29b. Signature and title of certifier

31. Date filed (Month.

FI May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 32. Registrar's Signature

Frank J. Mayo, MD, 16220 Frederick Road, Suite 213, Gaithersburg, MD 20877

29c. License number

D23630

May 19, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 Jerry Lawrence Long, Sr. 4:10 A^M May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie Baltimore Washington Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Jan. 3, Min 1**X** M 2 □ F Days Hours Washington, D.C Director 70 577-54-0503 Usual Residence of Decedent Silvens be more than an area and selected and white the selected show its marked other than "natural", or items 23a or 28a-f show as immaric event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 Yes 2 No MD Anne Arundel Crofton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21114 1406 Nutwood Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married ģ Yes 2X No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sheet Metal Mechanic traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fil of Health and Mental item 27 is marked မ Mildred Summers Leon Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1406 Nutwood Ct., Crofton, MD 21114 Charlotte M. Long / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 5/20/2011 Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Laft 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of): Approximate Onset and Death ₽hysician/ Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit law requires that the death certificate be executed Hyperlipidemia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 performed? 2 No 1 Yes Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 I 28c. Injury at work? Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: or Attending 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Pract or. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

of Vital Division To the within 2

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records,

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

277 Peninsula Farm Rd., Garth A. Ashbeck, M.D. 32. Registrar's Signature

D0060752

May 20, 2011

Arnold, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mav Month Physician/ 2011 a^{M} Miyoko O. Mills 25 3:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8610 Snowden River Pkwy Apt. Columbia 109 Howard 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏝 F Months Hours 223-06-6646 1070171942 Director 68 Japan Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Howard Columbia 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? Funeral or items 23a United States 8610 Snowden River Pkwy. Apt. 109 21045 filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes Give Asian "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Manager Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kiyoshi Obata Michi Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Marlene Mills Muchnick - Dau. 7579 Weather Worn Way unit E Columbia, Md. 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Page 1 ; 1 Burial 2 Cremation 3 Removal from State 5/25/2011 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. Signature of Funeral Service/Liv 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 as the t IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 9 Unknown Unknown P.O. I Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending Physician: The law requires 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform hours after death. uneral Director. After this certificate I completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 M Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a To the Funeral L Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Day 20 201 Physician/ GLENN B. MAYO 03: 18AM Medical 4a. Facility Name (if not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Lisbun Hospic If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Min. 210-38-0618 1. M 2 - F 63 Months Hours 09-22-1947 Country) Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at Director Princess Anne 1 Yes 2 No Somerset Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21853 Funeral 23a 28154 Venton Rd. United States items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, 11. Marital Status Armed Forces? 1968 Black, White, etc. ō þ 1 Never Married 2 Married Specify: Native American Gilena Hay & Baltimore, Maryland 21215-0036 1969 1 ☐ Yes 2 No Specify: and Mental Hygiene. Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Machinist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Percy Mayo Doris Rogers permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 28154 Venton Rd., Princess Anne, Md. Wife Georgie Mayo 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 24 05 Salisbury, Md. Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home Moo295 11673 Somerset Ave, Princess Anne, 21853 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate hock, or heart failure. List only one cause on each line Interval Between Onset and Death ediate Cause (Final MAHENANT Physician/ COLON resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any. leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? γ 1 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 D HOSDICZE မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work' 1 Ves 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 2ď11 5:30 Рм Bertha Louise McKenzie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Hours (Month, Day, Y March 21 220-28-8808 77 Maryland **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Maryland Frederick Frederick 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 21703 United States 5715 Elmer Derr Road 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Yes Maryland 21215-0036 White 1 Yes 2 No Specify. If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than Clothing Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file ည Agnes Price Carl Shores or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14 Concord Dr., Brunswick, MD 21716 . Page 1 and 2 sh ment of Health a tant: If item 27 is Cathy Spence / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any Injury or ot cemetery, crematory or other place)
Resthaven 1 X Burial 2 Cremation 3 Removal from State May 24, 2011 Frederick, Maryland 4 Donation 5 Other (Specify) Memorial Gardens . Signature uneral Service Licenses Resthaven Funeral Services, Skkot Cody P.A. M01237 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease of complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician TROKE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): inding physician a use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) cate has been signed by the apage 2 should be detached 1 ☐ Yes 2 ₽ g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{No} \) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) retime ander , M.D. MDD 64910 5/20/11

State Registrar

DHMH 17 Rev 7/2009

Frederick, mo

400 W 744 St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ratima lander

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Medical Edmund Burke Mason, II АМ 2011 1:44 May 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Crofton 1825 Braddock Drive If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 57 Yrs. 8. Date of Birth **Funeral** (Month, Day) Days 1 🛛 M 2 🗆 F Months Hours Louisiana 219-62-1805 វែ953 Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event: the Marked. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Crofton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21114 USA 1825 Braddock Drive 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, X Yes 2 No 1979-Yes, Give 2000 Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2000 1 ☐ Yes 2 XNo Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sarah E. Matthews Ed Wood Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1825 Braddock Drive Crofton, MD 21114 Dr. Anne N. Bowen / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 31 May 31, 2011 1 XBurial 2 Cremation 3 Removal from State Crownsville, MD MD Veterans Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Ulmonar disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any hading to in mediate cause. Enter Underlying Examiner coho To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and I-tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year 2 No by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to Completed by 1 ☐ Yes 2 **3**No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' 2 🖺 No Yes 2 No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🛍 No 1 Tyes |@ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Matural Natural injury 5 Pending 1 Yes 2 🗌 No Accident
Suicide Investigation 3 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier SIN SIN 00019301 mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person wh Read Army Medical Center Washington, De 20307 WAITER

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jon Allen MOWEN 8:28 PM 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown Meritus Medical Center 5. Social Security Number 8. Date of Birth (Month, Day, You Nov. 13, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🙀 M 2 🗆 F Hours Min. 1944 Mary land 220-42-1592 66 **Director** Nov. Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Washington Smithsburg Maryland 1 Yes 2XXNo 10f. Zip Code 10g. Citizen of What Country? Funeral 21783 23a 22130 Jefferson Boulevard U.S.A. or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 X No ≥ Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: If Yes, Give "natural", 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 nd Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) truck mfg. test engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Mancini Blaine A. Mowen and 2 should be Health and Meter 27 is mark and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille E. Mowen - wife 22130 Jefferson Blvd., Smithsburg, Maryland 21783 item 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place)
Hagerstown Crematory permit, Page 1 Department of Important: If it any Injury or o 1 Burial 2 K Cremation 3 Removal from State $^{28}_{2011}$ Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician, Chron. Medical Due to (or as a consequence of): Examiner YONAY Sequentially list conditions, in any, leaving to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last burialphysician sthe burial Physician/Medical mellitus Diabetas requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav Pregnant at time of death signed by the a d be detached for g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 trikinown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician; The law page 2 s has autopsy performed this certificate 1 Yes 2 No ector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) Natural 5 \square Pending work?
1 ☐ Yes 2 ☐ No Accident within 24 hours after death
To the Funeral Director: / Investigation Suicide 6 Could not be 3 ☐ Suicide4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0060396 5/28/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MURSHED lingastown 21740 W D 31. Date filed (Month, Day, Year) MAY 3 2011 egistrar's Signature State Registrar

11-04125 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **Doris Mills** State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Da June 2, 2011 Medical Examiner Doris Jean Mills 0410 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Country Mary Land Months Davs Hours Director 220-42-3739 08/21/1944 1 M 2 X F 66 Yrs Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No 28a-f show Maryland Frederick Frederick altimore, MD 21215-0036
mit. Pages I and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene.
portant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 808 East South Street 21701 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Y Never Married 2 Married Yes 2 X No 3 Widowed 4 Divorced if Yes. Give Year 1 Yes 2 No specify: White Š 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Clerical Worker Technology 7 Techn 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Russell Franklin Mills, Sr. Clarine Armentrout 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Taylor / Sister 4910 C Meridian Way, #27, Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory 06/07/2011 Smithsburg, Maryland 4 Donation 5 Other Specify 21. Signary e of Funeral Service License Keeney and Basford PA Funeral Home, MO1473 106 East Church Street, Frederick, oplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart art I. Enter the disease, or or Approximate Interval **Physician** failure. List only one cause Between Onset and /Medical a Smoke Inhalation and Thermal Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause: Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Division of Vital Records, P.O. Box 68760, tol or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED ned by the attending physician detached for use as the burial -AMENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Year Day 2 past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 V No 3 Probably 4 Unknown Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? page certificate Yes 2 No 1 🕢 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other this 1 Yes After 28a. Date of Injury 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Auto-within 24 hours after death.

To the Funeral Director: Af Jun 2, 2011 1 Natural louse fire 0300 hrs Pending 1 Yes 2 ✓ No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 808 E. South Street, Frederick, MD determined (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Che one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD As 31. Date filed (Month, Day, Year)

2011

llai

32. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

O.C.M.E.

June 2, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Jun 2 Physician/ 11:25 AM Nora Nixon Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Health Nur. & Rehab. Ctr. Allegany Cumberland 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day,) Feb 13 1 M 2 D.F Months Days Hours Director 234-38-8581 85 Usual Residence of Deceden item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD Allegany 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21502 USA 11217 Brown Hill Road should be filed within 72 hours after death and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces 1 Never Married 2 X Married 2 🗷 No þ ☐ Yes 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify: Completed 3 Widowed 4 Divorced white Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bessie (Gatlett) Morland Albert Morland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau MD 21502 Jerry Nixon Sr. 11217 Brown Hill Road husband Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Veterans Cemetery 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 6/6/2011 MD Flintstone 4 ☐ Denation 5 ☐ Other (Specify) Signature f Funeral Service 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 the as IE FEMALE nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy o in the past 12 mon Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify, funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 V Natural 5 Pending work 1 🗌 Yes 2 🗌 No Investigation Could not be the f Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined the Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Sepature and title of certifie 29d. Date signed (Month, Day, Year) 23a) (Type, Print) ss of person who completed cause State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Monthay 18 ay 2011 ear 0900А м Jo Ann Koral Peterson Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 10808 Gulfstream Court Damascus 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Months Hours Mir May 117, 1953 Director New York Yrs 58 297-50-6182 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Damascus Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20872 10808 Gulfstream Court USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify 3 Widowed 4 Divorced Completed White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Josephine Ruggieri John Koral, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 street of Health a ant: If item 27 is 10808 Gulfstream Court, Damascus, MD 20872 James B. Peterson, Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of h
Important: If ite 1 🗆 Burial 2 🖫 Cremation 3 🗀 Removal from State Metropolitan injury 4 Donation 5 Other (Specify) 05/25/2011 Alexandria, Virginia Crematorium, Inc. Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 20872 Signature of Fineral enviced i aka 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) mo Medical Due to (or as I consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificate Yes 2 or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After t 28d. Describe how injury occurred 1X Natural 5 \square Pending work? 1 Yes 2 No s after death. Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide within 24 hours a

To the Funeral D Hospital Medical Certiving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier rtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

15

30. Name and

31. Date filed (Month

Martin Joseph Edelman,

22 South Greene Street, Baltimore, MD Suite N9E08

ess of person who completed cause of death (Item 23a) (Type, Print)

MD

Registrar's Signature

11-03923 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jason Ryan Presgraves State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Oa May 25, 2011 Jason Ryan PRESGRAVES **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Oeath 1124 W. Irvin Avenue Washington Hagerstown 5. Social Security Number **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Oate of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days Director 214-13-3799 1 X M 2 F 37 24,1973 Usual Residence of Decedent 10b. County 10c. City. Town or Location other than "natural", or items 23a or 28a-f show the Medical Examiner resist be notified at ence. Maryland Washington Hagerstown Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 23s-f sho
injury or other traumatic event, the Medical Examiner must be muffled at user. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1124 W. Irvin Avenue 21742 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 1 Yes 3 Widowed If Yes, Give Year 4 Oivorced 1 Yes 2 X No specify: Specify. 2 or Date: 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. OO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 copier technician processing service 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be William Presgraves Vicki Horine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٩ Lorraine Presgraves - wife 1124 W.Irvin Avenue, Hagerstown, Md. 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 5/31/11 Hagerstown, Maryland Donation 5 Other Specify 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Censes 415 E.Wilson Blvd., Hagerstown, Md. s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** 23a. Part I, Enter the disease, or failure. List only one cause /Medical a. Asphyxia Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated Due to (or as a consequence of): events resulting in death) Last n and - transit cal has been signed by the attending physician as 2 should be detached for use as the burial -**AMENDED** UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy 2 past 12 months' Pregnant at time of death 5 Other (Specify) Physi 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Completed 24a. Was an autopsy performed? Yes 2 ✔ No this certificate After this certific funeral director, p 25. Was case referred to medica 26.Place of Death (Check only one) Be Hospital: 1 Inpatient ER/Outpatient 3 DOA 1 Yes 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? May 25, 2011 Subject hanged self Natural 2219 hrs 5 Pending 1 Yes 2 V No the 2 Accident Investigation

23d. Oate of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: within 24 hours after death. Other 1 Nursing Home 5 Residence 6 🗹 Other: Scene 28d. Describe how injury occurred Certification: To the Funeral Director: completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide 6 Could not be or Town, State) 1124 W. Irvin Avenue, Hagerstown, MD (Specify) Single Family Home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 26, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner 32. Registrar's Signature State Registrar **ORIGINAL OCME**

18537

2230 hrs

Country) Maryland

10d. Inside City Limits

1 X Yes 2 No

white

21740

Approximate Interval

Between Onset and

Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 8538 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year RICE NE 1602 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last hirthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 1 7 2 2 / 1 9 2 6 578-30-2030 85 Yrs DC **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the state of the state o 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Anne Arundel Annapolis 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Apt. 814 21401 'USA 130 Hearne Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2X No Specify. Specify Completed 3 Wildowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) 12 College (1-4 or 5+) Chief Dietician Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Stella Himelright George McCoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ira Price Son 6907 Elbrook RD. Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date UNK 1XXBurial 2 Cremation 3 Removal from State Arlington, VA Arlington National 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau, on each line. Approximate Interval Between Immediate Cause (Final Opeet and Death on Ch Physician. disease or condition / Medical resulting in death) Due to (or as a consequence of): Examiner MI Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence or). To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a d be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been signated to page 2 should to Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? this certificate Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 21438 Name and address of person who completed cause of death (Item 23a) (Type NNAPOLIS MO21401 M Twy N m La 746 gistrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 29, 2011 Physician/ Blanche T. Quade 4:05 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital St. Mary's Leonardtown . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Aug. 19, Year 1934 Maryland 76 216-30-4062 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10c. City. Town or Location Director Maryland St. Mary's Mechanicsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37765 Asher Rd. 20659 United States 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the once. School Board Cook Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James T. Hill Annie Farrell 19a. Informant's Name/Relationship (Type, Print)

Donna M. DeMent/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, **37765 Asher Rd., Mechanicsville, MD** 20659 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 3, 1 Burial 2 Cremation 3 Removal from State Maryland Veterans Cem. 4 Donation 5 Other (Specify) 2011 Cheltenham, MD 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DNEVILLONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) nding physician Physician/Medical death certificate be use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 T Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 4 Pregnant a
9 Unknown the a 1 ☐ Yes ∠ac 9 ☐ Unknown signed by the signed by the signer of the si ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2-No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 No has page 2 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ြို 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 \square Pending injury 1 Natural Accident Investigation after death completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of ertifier MD D56096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOGNIA LEONARD TOWN 20650 RAJBINDER MATTYS GILL 31. Date filed (Month, Day, Year) egistrar's Signature JUN 0 2 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 06 a M Donna Marie Rose /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Plata Civista Medical La ter en If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, . Age (In yrs. last birthday) **Funeral** Year) 1 □ M 2 X F Months Days Hours Min. 1949 Pennsylvania Director 201-40-0859 Nov. 61 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or than "natural", or Items 23a or 28a-f show 1 ☐Yes 2 ☐No Completed by Funeral Director Charles Maryland Bryans Road 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20616 U.S.A. 6853 Arbor Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 5-003 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade com (Give kind of work done during most of working life. DO NOT use retired) grade completed College (1-4or 5+) Elementary/Secondary (0-12) Is marked other than Homemaker Her Home 12 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be and 2 should be flealth and Mental Anna Marie Evans Orval Watson ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 I 6853 Arbor Lane, Bryans Road, Md. 20616 James Ernest Rose Husband Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) May 27, 2011 20c. Location - City or Town, State 20a. Method of Disposition o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit, Page Department Waldorf, Maryland 4 Donation 5 Other (Specify) Gardens Memorial 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service L M00668 4270 Hawthorne Rd., Indian Hrad, Md. 20640 23a. Part 1. En er the disease, or complications that caused the death. Do not enter in mode of dying, such as cardiac or respiratory arrest, shock, othe rt failure. List only one cause on each line Immediate Cause (Final **Physician** /Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or highly that initiated events resulting in death) Last guence of Examiner Physician: The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent prognant 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? of Vital Records, Be Completed by 3 Probably 4 Unknown 1 Yes 2 No 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy perform 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐No After this certific funeral director, 25. Was cas referrexaminer? to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ₩No 2 ER/Outpatient 3 DOA 1 ☐ Yes Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Many er of Death 28b. Time of Injury 28d. Describe how injury occurred Division or Attending 1 V Natural 5 Pending ours after death, neral Director; Ai filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C Hospital 29a, Certifier ACTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check onl one) and manner stated 29b, Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NBZ

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 20 TT 5, 3:10 Ам CARL EDWARD RENTZELL .TR Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Days Min. Jan. 10,1941 212-38-9446 70 Hours Mary Yand **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at death with the Maryland 10a, State 10b. County 10c. City, Town or Location Director 10d, Inside City Limits 1 ☐ Yes 2 🙀 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4742 Teen Barnes Road 21703 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced 1960-1964 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing <u>Facility Maintenance</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carl Edward Rentzell Sr. Hazel Gertrude Baughman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Healt Important: If item 2? any injury or other t <u>Susan Rentzell</u> (Wife) <u>4742 Teen Barnes Rd., Frederick, Maryland 21703</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Restricted) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/10/2011 Gardens Frederick, Maryland Signature of Funeral Service Licensee Reeney & Basford P.A. Funeral Home 106 East Church St., Frederick, MD MO1612 23a. Part Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ atecular octen F disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth
Pregnant
Unknown in the past 12 months? Month Pregnant at time of death Day 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ors. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 **H**o Other: Certificate: To 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 046248 5)11 15 \$1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pierce ath Frederick, MD 2170 Martha 300 w Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

JUN 1 0 2019

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ William Robertson :10 P 2011 Medical Mav 30 4a. Facility Name (if not institution, give street and number) 4c. County of Death
St. Mary s 4b. City, Town, or Location of Death Examiner Charlotte Hall Charlotte Hall Veterans Home Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Septh De 1923 Months Hours Min Pennsylvania 87 Yrs **Director** 186-14-9668 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Charlotte Hall St. Mary's Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral United States 20622 29449 Charlotte Hall Rd. items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or Completed by Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: White Specify 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Senior Master Sergeant U.S. Airforce Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary E. Higgins William H. Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 271 01d House Rd., Ridgeland, SC 29936 William H. Robertson/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 1. 1 Burial 2 XCremation 3 Removal from State Brinsfield-Echols Crem. 4 Donation 5 Other (Specify) Charlotte Hall, MD 2011 of Funeral Service bicensee 21. Signatur, 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., MO0817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ALZHEIME Prrysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir sician and burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) anding physician ause as the burial-Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown g Unknown To the Hospital or Attending Physician: The law requires that the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ESSENTIAL HYPERTENSION Records, 1 Yes 2 No 3 Probably 4 Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has the autopsy **Division of Vital** 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 D Nursing Home 5 D Residence 6 D Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t Certificate: 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No injury 5 Pending Accident
Suicide Investigation within 24 hours after death To the Funeral Director. / completed filled in by the i 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Efertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D0067788 MD 5.31.2011 Re 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEENA RAO KODALI, Charlotte Hall MD 31. Date filed (Month, Day, Year) State Registrar JUN 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jeffery Rehmann Shirley 2:10 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) lay 26,1926 Hours 218-40-2144 84 Pennsylvania Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits with the Maryland must be notified at Director Severna Park Anne Arundel MD 28a-f 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA items 23a 21146 600 McKinsey Park Drive, Apt. 203 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner REAMINAL SITIES Black White etc. Completed by ò 1 Never Married 2 Married Yes 2 X No Specify White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-003 "natural", 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HealthCare Registered Nurse Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, once. Be 18. Mother's Name (First, Middle, Maiden Surname)
Almeda Mae Klinger 17. Father's Name (First, Middle, Last, 2 Earl Wesley Jeffery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Severna Park, MD 21146 484 White Cedar Lane <u>Katherine Rehmann-Buchman</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Gardens of Faith
Cemetery Baltimore, MD 28,2011 May 4 Donation 5 Other (Specify) permit. Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licenses Severna Park, MD 21146 495 Ritchie Hwy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ myocan disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year 1 Yes 2 9 Unknown signed by the a 9 Unknown Hospital or Attending Physician: The law requires that the t24 hours after death.
Funeral Director; After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy 2 No 1 Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 ပ 1 Tes 1 npatient 2 -ER/Outpatient 3 DOA Manner of Death

Natural

Accident Date of injury 28b, Time of Certificate; 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending 1 Yes 2 No Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier 🔾 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contributing Number Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Day, Year) MO6 Name and address of bersol who completed cause of death (Item 233) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

iled (Month, Day, Year)

4

11-03953	Please Type or Print in Black Indelible Ink. Ensure All Copartment of Health and Mental	pies Are Legible.									
Wilfredo Rodriguez	1- For State State of Maryland / Department of Health and Mental Certificate of Death	Hygiene 2011 8541									
Physician Medical Examine	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year May 27, 2011 3. Time of Death 0629 hrs									
	4a. Facility Name (if not institution, give street and number) University Hospital 4b. City, Town, or Location of De Baltimore	eath 4c. County of Death									
Funeral Director	624-25-7276 1XM 2F 37 Yrs.	AHrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)E1 Salvad									
Varyland 28a-f shaw any d at once.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Annapolis	10d. Inside City Limits 1 Yes 双区No									
n the Maryland 3a or 28a-f shi otified at once Director		10g. Citizen of What Country? El Salvador									
er death with , ar items 2 r must be a	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 15. Was Decedent of Hispanic Origin? 1 Yes 2 No 1 Yes 2 No specify: S.	erto Rican, etc.) White, etc.									
2 hours aft "natural" Il Examine	16. Decedent's Education (Specify only bighest grade completed). 16. Decedent's Usual Occupation (Give kind	of work done 16b. Kind of Business/Industry retired)									
5-0036 led within 72 hour 1/3 giene. Tygiene "aatt the Medical Exa	Landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	Agriculture Jame (First, Middle, Maiden Surname)									
MD 21215-0036 nd 2 should be filed within 7 alth and Mental Hygiene. m 27 is marked uther than yaumatic event, the Medical	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 250 B Hilltop Ln. Ap)	Berta Escobar or Rural Route Number, City or Town, State, Zip Code)									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked uther than "natural", ar items 23a ar 28a-f sha injury or ather traumatic event, the Medical Examiner must be notified at once. To Ba Completed by Funeral Director	Blamea I. Contreras Wife 215B Firewood Ct. 20a. Method of Disposition 1 XXBurial 2 Cremation 3 Removal from State Carragory of Calverio 4 Donation 5 Other Specify:	Annapolis, MD 21403 Date UNK 20c. Location - City or Town, State El Salvador									
Baltir permit. I Departme Imports injury or	21. Signature of Funeral Service Licensee 22. Name and Address of Facility H 12 Ridgely Ave.	Hardesty Funeral Home, P.A. Annapolis, MD 21401									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	ac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death									
ted nsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or rignry that initiated events resulting in death). Last										
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transing chical Certification: To Be Completed by Physician/Medical Especial Certification: To Be Completed by Physician/Medical Especial Certification: To Be Completed by Physician/Medical Especial Certification: To Be Completed by Physician Medical Especial Certification: To Be Completed by Physician Medical Especial Certification:	IF FEMALE: 23a, b, 27 per me g917 7-21-11 vt IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23a, b, 27 per me g917 7-21-11 vt 23d. Date of delivery Month Day 4 Pregnant at time of death 5 Other (Specify) 9 Unknown										
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/ital Rec /sician: The his certificate director, page	25. Was case referred to medical 25. Place of Death (Che examiner? Hospital: Telephone Death (Che Death	eck only one) ursing Home 5 Residence 6 Other:									
on of Vi cading Physicath. Bath. arr. After this the funeral di	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work?	28d. Describe how injury occurred									
Division of a Division of a To the Hospital or Attending Phavitin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral confical Certification: Tedical Certification: T	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
To the Hos within 24 hb To the Fun completely											
	Ticlo Latter Jest 700 O.C.M.E.	May 28, 2011									
30	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltin	imore, MD 21223									
State Registra											

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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 21. HENRY SYLVESTER SPRIGGS MAY 2011 5:35 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CHESAPEAKE SHORES NURSING HOME ST. MARY'S COUNTY LEXINGTON PARK . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign AUGUST 11, 1940 MARYLAND **Director** 220-34-2530 70 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 👿 Yes 2 🗆 No MARYLAND CHARLES POMFRET 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5025 PRESTON LANE UNITED STATES 20675 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner 0 1 X Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12TH GRADE SERVICE WORKER GROCERY STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental GEORGE PHILLIP SPRIGGS MARGUERITE MATILDA BOWMAN SPRIGGS 19a. Informant's Name/Relationship (Type, Print) . Page 1 and 2 shoutment of Health and tant: If item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY EVELYN DASHIELL / SISTER P.O. BOX 98,5025 PRESTON LANE, POMFRET, MARYLAND 20675 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) CATHERINE CHURCH CEM. MAY 27,2011 MC CONCHIE, MARYLAND Signature of Funeral Service Vicense THORNTON FUNERAL HOME, P.A. THORNTON JOHNSON MOO583 LYDIA C. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown be detached for Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsy performed?

1 Yes 2 No certificate 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) 2 No Other: 1 Yes မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury s after death. 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause 784 01 31. Date filed (Month, Day, Year, 32. Rec State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 18546 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ mai 10:45 A M 24 2011 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MD Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace 1 🔀 M 2 🗆 F Min. 502-44-2515 Months Hours (Month, Day, North Dakota Director August 7 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Meetial Hygiene. Important: If teem 27 is and Meet of the than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Washington Keedysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4026 Trego Road 21756 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married milton R. Streife þ 1 Yes If Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Streifel Savelsberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce B. Streifel 4026 Trego Road, Keedysville, Maryland 21756 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Boonsboro Cemetery 05/30/11 Boonsboro, Maryland Inatu of Funeral Service bicenses 22. Name and Address of Facility Bast-Stauffer Funeral Home, 7606 Old National Pike, Boonsboro, Maryland 21713 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine ysician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death detached 9 Unknown 9 Unknown P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? 5 Records, 2 No 3 Probably 4 Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Tyes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1-1 Natural 5 Pending after death.

Director: At in by the fu 1 Tyes 2 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide To the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Scertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier R128088 02 Kute m Smith

State

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Hagerstown, MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 8547. Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month < Physician/ : 7/AM David Leroy SEIBERT, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Washington 17811 Woodcrest Road Hagerstown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** or Day, You Maryland Yrs Ĩ933 Director 220-28-3931 Nov. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits Examiner must be notified at 10c. City, Town or Location death with the Maryland Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 17811 Woodcrest Road 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates. 1 Yes 2 No Specify. 1951-54 Specify: white "natural", Completed 3X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Mechanic Aircraft event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o permit, Page 1 and 2 should be Department of Health and Menta Important. If item 27 is marked any injury or call. ၉ pe 1 Mary Ethel Miller David Leroy Seibert, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6924 Timber Creek Court, Clarksville, Md. 21029 Kevin Butts - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 5/31/2011 Hagerstown, Maryland Signature of Frieral Service I 22. Name and Address of Facility MINNICH FUNERAL HOME COOS Hagerstown, Md. 21740 Wilson Blvd., Ε. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine the burial-transit and attending physician Physician/Medical death certificate be P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at Id be detached for Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has performe within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes 2 25. Was case referred to prical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 D No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending injury Natural 1 Yes 2 No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29d. Date si ned (Month, Day, Year, 30. Name and address of person v no completed cause of (Type, Print) egistrar's Signatu State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:44 P M DOROTHY JUNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Numbe **Funeral** 1 🗆 M 2 💢 F Months Hours Min (Month, Day, Year) 1/27/1924 Marvland 218-12-0640 **Director** Usual Residence of Decedent show 10d. Inside City Limits at 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland **Funeral Director** or 28a-f sl 1 Yes 2 X No Frederick MD Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō Page 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene.

To File Title To Ty is marked other than "natural", or items 23a or the free Ty is marked other than "natural", or items 23a uny or other traumatic event, the Medical Examiner must be. United States 21703 6441 Jefferson Pike , Apt. #315 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black. White, etc. Completed by 1 Yes 2 If Yes, Give Year or Dates 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Western Electric Switchboard Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gertrude Bertram Howard L. Craven 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1440 Hunting Horn Lane, Frederick, MD 21703 James R. Secula / son 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 XBurial 2 Cremation 3 Removal from State Cheltenham Vets Cem. 6/13/2011 Cheltenham, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home Kne 106 E. Church St., Frederick, MD 21701 MO1222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ 25 LIS disease or condition resulting in death) Medical or as a consequence of Examiner 15 Urs mento Section tially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Pregnant at time of death detached the Unknown ģ s been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 으 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral 1 X Natural injur 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month. Day, Year) 6/6/2011 gerstown, MD

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** TAWES 19. 2011 6:00 P M T.TNWOOD JAMES May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crisfield Somerset McCready Memorial Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 04/08/1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Hours 1**∑**M 2□ F Maryland 213-24-2474 82 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes Ž\□No Maryland Crisfield Somerset Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21817 U.S.A. by Funeral 4408 Box Iron Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1946-1 ☐ Yes 2 🔀 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 1948 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecil Clark Vernon Tawes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4408 Box Iron Road - Crisfield, MD Flora Tawes (Wife) 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridge Mem. Park | 05/22/2011 | Crisfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Con-Robert H. Bradshaw, Jr. 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 HEIMERS DEMENTIA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ASCVD 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform

Physician /Medical Examiner

Funeral

Director

or items 23a or 28a-f show iminer must be notified at

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permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau

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Baltimore, Maryland 21215-0036

and burial-trai physician the signed by page

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Hospital within 24 hours a

Division or Vital Records, P.O. Box 68760,

certificate l funeral director After this affer death.

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Certification: To

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2

1□ Yes 2/2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2x No 2 ER/Outpatient 3 DOA 1 Inpatient Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred Injury 1XX Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

D 48098

Hall Highway, Crifield

19/2011

21817

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
D V 4 ay Kaum bunathan 201 Dr. Vyay

Hospital:

31. Date filed (Month, Day, Year)

25. Was case referred to medical

examiner?

(Check only

MAY 23 2011

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Lillian Trout Mae 2011 10:04 May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospice House of St. Mary's Callaway 8. Date of Birth (Month, Day, Year) 03/21/1925 Social Security Number 7. Age (In vrs. last birthday) Year If Under 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Hours Pennsylvania Director Yrs 201-12-6278 86 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notitied at once. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Leonardtown St. _Marv's 10f. Zip Code 10g, Citizen of What Country? Funeral 20810 Deer Wood Park Drive 20650 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes. Give Specify: White 3 ₺ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 10 Textile Winder Textile Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Scott Feather, Sr. Elizabeth Gilmore Flanagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie L. Laska / Daughter 20810 Deer Wood Park Drive, Leonardtown, MD 20650 20a. Method of Disposition June 2, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 2011 Signature of Funeral Service License 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A
P.O. Box 270, Leonardtown, Maryland 2 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final Physician/ cardiac disease or condition Medical resulting in death) Examiner Ronamina Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be inector, page 2 s autopsy perform Yes 2 No 2 🗌 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Hospice examiner? 2 1 🗌 Yes Other: House 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes s after death I Director: A d in by the fi ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I To the 29b. Sign*a*ture and title of certifier 29d. Date signed (Month, Day, Year) D47,597 6-1-11

10 km

Registrar
DHMH 17 Rev 7/2009

State

Jeffrey C.

31. Date filed (Month, Day, Year)

26840 Point Lookout Rd., Leonardtown, MD 20650

ddress of person who completed cause of death (Item 23a) (Type, Print)

istrar's Signature

Brown, M.D.

	nd #2 per)Health 1		5. 5–24–11 κ		Type or Pri State of M						-		-).
			State Registrar						te of E			Reg. N	2011	18551
ı	Physicia Medic	n/	1. Decedent's Name		schurc	h					2. Date of I Month May		2011 Year 2,0(1	3. Time of Death
	Examin	er		, 0	e street and number)	~0C=	atr			Location of De			c. County of De	ath
- 25	Funeral		5. Social Security Nu	umber 6.		e (In yrs. las	t birthday)	_	er 1 Year	If Under 24 H	rs. 8. Date of B	11.5	9. B	irthplace (State or Foreign
	Director		240-62-1 Usual Residence of	270	Mw 2 D1	71	Yrs.				Jan.	17,19	940 NO	rth Carolina
	laryland <mark>3a-f shov</mark> iified at	ector	10a. State MD	10b. County Anne Ar	rundel		Town or Lo Cambri							10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Num	lgeon Way	y Unit 103	 3		10f. Zi	p Code 2105	54		10g. C	Citizen of What C	Country?
36	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notifled at	वि	11. Marital Status 1 Never Marri 3 Widowed	ed 2 Married	12. Was Decedent I	Ever in U.S.	'	f Yes, spe	cify Cuba	ispanic Origin? n, Mexican, Pue Specify:	Specify Yes or Nerto Rican, etc.)	0-	14. Race - An Black, Wh Specify:	
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours nt of Health and Mental Hygiene. If item 27 is marked other than "naturi or other traumatic event, the Medical E	Completed		15. Decedent's cify only highest g	Education	5+1	life. D	kind of we O NOT us	ork done o se retired)	ation during most of w	rorking		Kind of Busines	
121	d withi lygiene ther th nt, the	lool	12			,,	Con	trac	tor				ontract	ıng
lanc	nould be filed within 72 and Mental Hygiene. s marked other than "I amatic event, the Med	To E	17. Father's Name (F	Upchure							lame (First, Midd Freema		n Surname)	
Mary	12 should lith and N 27 is ma r traumai		19a. Informant's Na	me/Relationship (** '		19b. Mailir 80 4	ng Addres Hed	s (Street a	and Number or i	Rural Route Num	ber, City o	or Town, State, 2	Zip Code) 21054
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 21 any injury or other t				Removal from State	20b. Pla	nce of Dispo metery, cren	Menic	other place ria I	e) Mag	y 25, 2011		Location - City	or Town, State
Baltir	permit. P Departm Importar any injur		21. Signature of Eur		**		B	Sarde Arra Arra	nd Addres	ss of Facility Sons,	P.A. Se	verna	a Park 1	Funeral Home MD 21146
		H	23a. Part 1. Enter the	disease or cor	nplications that caused one cause on each line	d the death.				LE HWY g, such as cardi			a Falk,	Approximate Interval Between
â	Physician/		Immediate Cause (I disease or condition	Final	a Rong	20 Fc	ulue	_						Onset and Death
	Medical Examiner		resulting in death)		Due to (or as	a conseque	ence of):							10 days
	n #	Examiner	Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or i	nditions, imediate	b. Due to (or a	a conseque	1 7							1000
	executec an and rial-transi		Cause (Disease or in that initiated events resulting in death) L	3	c. Due to (or as	a conseque		200	er					unknown.
09	ate be e shysicia the buri	dical		•	d									
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Yes 2 Unknown Yes 2 Ves 2 No Unknown Yes 2 Ves 3 Ves 3 Ves 4 V							÷у		-	23d. Date of delivery Month Day Year	
s, P.O.	ires that th signed by d be detac	d by Ph	Part II. Other signifi	_	contributing to death b	out not resu	Iting in the u	ınderlying	cause giv	ven in Part I.				to the cause of death?
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for	omplete		MONIA							24a. Wa	as an topsy rformed?	prior to	autopsy findings available occumpletion of cause of 2 1000 occurs
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ion o	tending leath. tor: After the funer	Certificate:	1 Natural 2 Accident 3 Suicide	5 Pending Investigation 6 Could not	(Month, Da	y, Year)	injury	М		Yes 2 No	28d. Describ			
Divis	ital or At urs after or ral Direct led in by		4 Homicide	determined		ury - At hon c. (Specify)	ne, farm, str	eet, facto	ry, office			(Street a Town, Stat		Rural Route Number,
	the Hosp in 24 hou the Funer	Medical	(Check 2 only one) 3	☐ Medical Exar ☐ Certifying Nu	ysician: To the best of niner: On the basis of e rse Practioner: To the	xamination	and/or inves	tigation, ir	n my opinio	on, death occurre	ed at the time, dat	e and plac	ce, and due to th	e cause(s) and manner stated.
	To To Con		29b. Signature and to	. \	acu				c. License	66817	23	29d. D	Pate signed (Mor	nth, Day, Year)
	4/0		30. Name and addre	ess of person who	361 HoS	leath (Item 2	23a) (Type, F					MD	2100	51
	Star Registra	·C	31. Date filed (Monti	7, Day, Year) YAY 242	361 H05 32. Registr	ar's Signatu	ire E. A	ark	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental HygieRe 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Da Vear **Physician** VOLK 9:45 AM alvin -2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fairfield Nursing Home Crownsville Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year 9/20/1924 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1<u>⊠</u>M 2□F Months Director 222-14-4179 86 PA Usual Residence of Deceden fited within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 ☐ No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1008 Sextant Ct. Completed by Funeral 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 DuPont Laboratory Tech. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If itam 27 Is marked of Howard Volk Nellie Brown ပ 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sallie Volk (Wife) 1008 Sextant Ct. Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State ŏ permit. Page Department of Important: If any injury or once. ⁴ □ Donation 5 □ Other (Specify) New London Presby. 5/27/2011 New London, PA 21. Signature of Funeral Savy Chicensee 22. Name and Address of Facility Hardesty Funeral Home 12 Ridgely Ave. Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 'S **Physician** inson disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Phyaician: The law requires that the death certificate be executed use as the burial-transit monas Due to (or as a consequence of) Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | detached 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Vursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Innatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funaral Diractor: A investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 🚰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0070693 05-23-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Colony Drive 1000 MATTBOOR SYET Suit Annapoli 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

MAY 2 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 23, Physician/ 201^{Year} 0123 A Arlene Amanda Wagner Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🛢 F Months Hours Min. (Month, Day, Year) Dec. 27, 1918 Director 92 Dec. Pennsylvania 202-10-0373 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c, City, Town or Location Director 1 Yes 2 No Maryland Monrovia Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 11899 Barley Ct. 21770 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles M. Mohl Cora Mengel Mohl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11899 Barley Court, Monrovia, Maryland 21770 Karen Kranz, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cernetery, crematory or other place)

Metropolitan
Crematorium, Inc. May 24,2011 1 🗆 Burial 2 🖷 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Tineral Service La Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, MD 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause or reach line. Approximate Interval Between Onset and Death Immediate Cause (Final Po Ph. sician/ disease or condition resulting in death) minutes Medical Due to (or as a consequence of): Examiner ASPIRATION PNEUMONIA weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events DISEASE ALZHEL Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION Completed peen (24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 🗌 Yes 2 🔲 No certificate eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospice Other: 2 No 1 Tyes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work 1 Tyes 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Human

Registrar
DHMH 17 Rev 7/2009

5

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUSSANOV

NAAZ

31. Date filed (Month, Day, Year)

04676

DRIVE FREDERICK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend#II,12,13perfng916,6-20-IIdo
State of Maryland / Department of Health and Mental Hygiene

Amend item#21perfun g916,6-14-2011 d.o.

Reg. N2 0 | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month _ Day 1.23AM 2011 Marie F. Anacker Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BURNIE A-RUNDE BALTIMORE INASHINGTON MEDICAL CENTREP GLEN ANME 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Pays Year) 1 M 2 XF MaryTand Director 218-16-2211 86 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits Director 1 🗌 Yes 2 🗌 No Linthicum Heights MD Anne Arundel 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral USA 104 Sycamore Road 21090 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked Africa. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 Yes Completed by 1 Yes 2 No Specify: 3 🔀 Widowed 4 🗆 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles L. Miller Marie <u>F. Fehte</u> 子となるのかが 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald C. Anacker / Son 116 Homewood Rd. Linthicum Heights, Md. 21090 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 6/15/11 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Pask Funeral Home Eugene Lastner, JR m00355 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ANOTIC Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Physician/Medical Division of Vital Records, $\overrightarrow{\mathsf{P.O.Box}}$ 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should i 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ☐ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) **Director:** After this of in by the funeral dir 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending iniury Investigation Accident Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI 2011 Name and address of person who com et od cause of death (Item 23a) (Type, Print) Glen Burnie MD 20161 ABA 501 C 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 18555 State of Maryland / Department of Health and Mental Hygiens, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OG Physician/ MA [2:00 Medical Name (if not institution, give street and number) 4c. County of Death 4b. City, Town or Location of Death Examiner BAH MOR 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** Months Hours **Director** 10c. City, Town or Location 28a-f show 10d. Inside City Limits 10b. County at 10a. State Director must be notified 1 Ves 2 No Timore 10f. Zip Code 10g. Citizen of What Country? ò Funeral items 23a enue . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or ģ Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Black Completed 3 ₩Widowed 4 Divorced injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) Be 18. M er's Name (First, Middle, Ma 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or care မ towlard Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (To 19b. Mailing Address (Street and Number Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5 4 Donation 5 Other (Specify) 21. Signature of Funeral Whylce Licenses Edmondson Av. Balto. M. 2700 Service 23a. Part 1. Erret the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearl failure. List only one cause on each line. Approximate 3/10 Interval Between Onset and Death Immediate Cause (Final Ph sician/ erebro Vasc disease or condition Medical resulting in death) e to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine yper tension burial-trar Due to (or as a consequence of) physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) signed by the a d be detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy perfor death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d Describe how injury occurred Certificate: iniury Natural 5 Pending Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗍 only one) 29b. Signature and title of certifie 06/06/201 Temesquar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Ballimure 601 32. Registraris Signature State Registrar

DHMH 17 Rev 7/2009

			State of Maryland / De	partment of Health ertificate of Death			0	0 1 1	IOFEC
			Registrar 1. Decedent's Name (First, Middle, Last)	Fillicate of Death		2. Date of De	Reg. No.	ULL	8556
	Physicia		Diana B. Asare			June 7	Day	Year	12:40 P M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location	n of Death		ounty of Death		
			Holy Cross Hospital	Silver S	Spring	5		Mont	gomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Davs Hours	er 24 Hrs. Min.	8. Date of Bir	th v Year)	Cour	nplace (State or Foreign
	Director		216-17-8391 57 Yrs. Usual Residence of Decedent			July 28,	1953	Ghai	na
	ind show at	ō.	10a. State 10b. County 10c. City, Town or	Location					10d. Inside City Limits
	faryla Sa-f s tiffied	ect	Maryland Montgomery	Silver Sprin	nø				1 ☐ Yes 2 X No
	the N	٥	10e. Street and Number	10f. Zip Code	0	10g. Citize	n of What Cou	intry?	
	s 23a	Funeral Director	3522 Pear Tree Court, Apt.#33	20906	5		Uni	ted Sta	ites
	death item ner m		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of Hispanic On If Yes, specify Cuban, Mexica	Origin? (Spec	cify Yes or No- Rican, etc.)	14	. Race - Ameri Black, White,	
22	after l", or xami	d by	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 🗶 No Specify		, ,	Sp	pecify: Blac	
3	atura cal E	Completed	Total of Bates.	cedent's Usual Occupation			_		
2	72 h an "na Medi	mpl	(Specify only highest grade completed) (Gi	ve kind of work done during mo. DO NOT use retired)	ost of workir	ng	160. KING	l of Business Ir	adustry
7	within giene er tha the l		Elementary/Seconday (0-12) College (1-4 or 5+)	Self Employed			Resid	lential	Cleaning
2	filed al Hyg	Be (17. Father's Name (First, Middle, Last)	18. Moti	ther's Name	(First, Middle,			
<u>8</u>	ld be Menta arked atic e	욘	Jeffery Boateng	Fel:	icia A	Akyaah			
<u> </u>	shou and is m		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Numb	ber or Rural	Route Numbe	r, City or To	wn, State, Zip	Code)
2 15	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The and Mental Hygiene. The same 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			Pear Tree Court					
2	Page 1 ament of Hant of Hant: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition 20b. Place of Disposition 20b. Place of Disposition	position (Name of rematory or other place) ry ium, Inc.	D	ate	20c. Loca	ation - City or T	own, State
Daltillo	it. Pag rtmer rtant njury		4 Donation 5 Other (Specify)	ium, Inc.	June 10), 2011	Beth	esda, M	laryland
ם	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Service License Hauen Moloso	22. Name and Address of Faci Robert A. Pumph 800 W. Montgome	hrey l ry Av	Funeral	Home kvill	, Rock	ville, Inc. vland 20850
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.						Approximate Interval Between
- F	Physician/		Immediate Cause (Final disease or condition Hypertension						Onset and Death
	Medical Examiner		resulting in death) a. Due to (or as a consequence of):						
		ř	Sequentially list conditions, b.						
	sit id	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying						
	ecute and I-tran	Exal	Cause (Lisease or iinjury that initiated events c						
	ate be executed hysician and the burial-transit	dical I							
Š	icate p phys s the	ledi	d						
3	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1				23	d. Date of deliv	very
	death e atte	sicia	1 Yes 2 No 4 Pregnant at time of death	B				Month	Day Year
	the c by th tache	hy	9 🗆 Unknown						
-	s thal gned oe de	þ	Part II. Other significant conditions contributing to death but not resulting in the	a underlying cause given in Part	rt I.				the cause of death?
<u> </u>	quire en si ould l	ted	Anemia			1 🗆	Yes 2 🗆	No 3 ∐ Pro	bably 4 X Unknown
5	aw re as be	Completed	Dementia			24a. Was autor	osv	prior to co	opsy findings available ompletion of cause of
	The page	Co				1 Yes	ormed? 2 X No	death?	2 🗆 No
5	ician: sertific ector,	m	25. Was case referred to medical examiner?	26. Place of De	eath (Check	only one)			
	Physi this c	2	1 ☐ Yes 2 ☒ No ☐ 1 ☐ Inpatient 2 ☒ ER/Outpat 27. Manner of Death			me 5 Resid			y)
) =	ding h. After funer	Certificate:	1 XNatural 5 Pending (Month, Day, Year) injury		_	28d. Describe h	now injury o	ccurred	
2	Atten deat ctor: y the	ij	2 Accident Investigation 3 Suicide 6 Could not be 4 Description determined 28e. Place of Injury - At home, farm,		_	28f Location (9	Street and N	lumber or Rura	al Route Number,
	al or A s after Dire d in b	S	4 Homicide determined building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Tou		iambor or riore	arribate rambon
1	ospitz hours ineral d fille	edical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, dear	h occured at the time, date and	d place, and	d due to the ca	use(s) and r	manner as stat	ed.
	he Ho in 24 he Fu iplete	Mec	(Check 2 Medical Examiner: On the basis of examination and/or involved only one) 3 Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death on the stime, daise, death occurred at the time, daise.	occurred at ate and place	the time, date a e, and due to th	and place, ar e cause(s) a	nd due to the ca nd manner as s	ause(s) and manner stated tated.
	Vith vith Com		29b. Signature and title of certifier	29c. License number			29d. Date s	signed (Month,	Day, Year)
				D0064	4624		June	8, 201	11
			30. Name and address of person who completed cause of death (Item 23a) (Type	*					
2			Sandeep Sharma, M.D. 743 Summer Wal		hersbu	ırg, Ma	rylan	d 20878	3
	Stat Registra		31. Date filed (Month, Day, Year) JUN 13 2011 Server 3. Agark	/					
			* * * * * * * * * * * * * * * * * * * *						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lorain 20 ľ ľ Cass Albrittain June Medical 12:00 P M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9913 Old Spring Road Montgomery Kensington 5. Social Security Number **Funeral** . Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Hours March 30, **Director** 555-30-5974 Yrs 94 Arkansas Usual Residence of Decedent show at 10a State with the Maryland 10b. Counts 10c. City, Town or Location Director 10d. Inside City Limits r 28a-f sl notified Maryland 1 Yes 2 X No Montgomery Kensington 0 10e. Street and Number 10f. Zip Code must be i 10a. Citizen of What Country? Funeral 9913 Old Spring Road 20895 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Per 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give ò Examin Ş 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Completed 3 X Widowed 4 Divorced Specify Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Central Intelligence Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Agency traumatic event, Be 17. Father's Name (First, Middle, Last) and Mental F 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic events. ပ Maynard Laura (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Paul K. Robert / POA 9911 Parkwood Drive, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 11, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Montgomery Crematorium, Inc. 2011 Bethesda, Maryland 21. Signature of Funeral Service Licen Robert A. Artimorfice Tuneral Home Bethesda-Chevy Chase, Inc. D.Far M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Onset and Death Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Aspiration Pneumonia Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to lor as a consequence of and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?

1 Yes 2 X No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 X No page After this certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 X Yes 2 No Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 deficiency in various in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature 29d. Date signed (Month, Day, Year) MO D0063156 June 8, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Leon Pendergraph,

JUN 1 3 2011

31. Date filed (Month, Day, Year)

Jr. M.D.

32. Registrar's

8901 Wisconsin Avenue, Bethesda, Maryland 20889

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Jacqueline Lee 15:45 06 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Union Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 1 M 2 KF Months (Month, Day, Year Oct 23 62 Director 213-52-6328 1948 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21211 3939 Roland Ave. Apt. United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced "natural" Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Book Bindery Book Binding traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ should be Stanfield Eugene Walter Charlotte Mead Wilhide 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trac Susan Lamp /Sister 3736 Elm Ave. Baltimore, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Page 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Jun 1 Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives 401585 hebacca 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Anset and Death ten Physician/ pheral Disease disease or condition resulting in death)) years Medical Due to (or * a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury signed by the attending physician and a be detached for use as the burial-transit asomolor that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No ည ☐ Inpatient 2 □ ER/Outpatient 3 DOA in 24 hours after death.

The Funeral Director: After the collected filled in by the funeral funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Investigation
6 Could not be 1 Tes 2 🗌 No Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Certifying Nurse Practions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 30. Name and address of person who etee cause of death (Item 23a) (Type, Print) Universil

DHMH 17 Rev 7/2009

State Registrar

Va 2

32. Registrar's Signature

Couchine 31. Date filed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2011)une 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) None **Baltimore City** The Johns Hopkins Hospital 9. Birthplace (State or Foreign Country) 1930 Maryland 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
May 23, 5. Social Security Number 1 M 2 XF 578-38-9604 81 May Usual Residence of Decedent

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Ι.	.	10a. State	10b. County			10c. City	, Town	or Locat	ion						Tod. Inside City Life	
	200	MD	Montg	omer	У	В	ethe	esda						_	1x Yes 2 □] NO
	Funeral Director	10e. Street and Nur							10f. Zip-Code				10g. C	itizen of What Co	untry?	
-	a L	5450 Wh:	Terrace	503	3		20814				USA					
	ner	11. Marital Status		12	. Was Decedent I Armed Forces?	Ever in U.S	rer in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-						14. Race - Ame Black, White			
	₹	1 Never Marri		ed	1 ☐ Yes 2X If Yes, Give	No							Specify: Wh			
ا ا	Completed by	3 🗽 Widowed	4 Divorced		Year or Dates:											
	ere	(Spec	15. Decedent cify only highes				1 /	Give kir.	nt's Usual Occ ad of work dor	e durina m	ost of work	king	16b.	Kind of Business	Industry	
	ᇍ	Elementary/Seco	ondary (0-12)	T	College (1-4 or 5	i+)	1		NOT use retir	-				0 11		
		12 17. Father's Name	/Eiret Middle I	act)				но	memake		ther's Nam	ne (First, Middl		Own Home	<u> </u>	
	<u> </u>												, , , , , ,	,		
l P	2	Theodore Zinnamon Sylvia Cohen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, or											ber City	or Town State 2	Zip Code)	
		Gary A.					1	_						ryland 2		
1	-				-	20h B	lace of	Dienneit	ion (Name of		,	Date		Location - City or		
	1 SBurial 2 Cremation 3 Removal from State Legiptery, (rematory or other place)									•						
	-		5 Other (Sp			Mem	oria				1				ch, Virgi	
Olice		21. Signature of Fu			mo15	O 7_									rection,	
OI.			/			_								ie, mary	1and 2085 Approximate	
	- [23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													Interval Betweer Onset and Deat	
		Immediate Cause (Final disease or condition a.														
		Due to ras a consequence of):														
	<u>.</u>	Sequentially list co	nditions,	b.				0								
	בַּ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury														
	Examine	that initiated events resulting in death) Last Due to (or as a consequence of):														
4	20	d														
	Completed by Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date o											23d. Date of de	livon		
	Sian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 5 Copic pregnancy 4 Pregnant at time of death 5 Other (specify)											Month	Day Year		
	ÌSÍ	1 Tes 2 Unknown			9 Unknown	t time or or										
Ē	7	Part II. Other signi	ificant condition	ons contr	ributing to death t	out not res	ulting in	the un	derlying cause	given in P	art I.	23e. Did	tobacc	o use contribute t	o the cause of death	h?
1 3	6											1 🗆	Yes	2XNo 3 □ P	robably 4 🗌 Unkn	nown
1	ete											24a. Was	an			
	E E											auto	opsy formed?	prior to death?	completion of caus	e of
												1 ☐ Yes	2 💢 I	No 1 ☐ Yes	3 2 No	
10	ň	25. Was case refer examiner?			ospital:				a 🗆 po. 1)ther		th (Check only		C Other (Co.	-16.1	
É	0	1 Yes 2 X			28a. Date of Inju			ime of	3 □ DOA 28c. Ir	4 🗆	Nursing Ho	28d. Describe		6 Other (Spe	Спу)	
	<u> </u>	1 X Natural	5 Pending	g	(Month, Da	y Year)	Ir	njury	W	ork?	□No			,,		
	cat	2 ☐ Accident 3 ☐ Suicide	6 Could	not be	28e. Place of inj	ury - At ho	me fan	m. stree	1.1			28f. Location	(Street	and Number or F	Rural Route Number,	
	토	4 Homicide	determ	ined	building, et	c. (Specify	1)	,	-,,,	-		City or To	wn, Sta	te)		
9	Medical Certification:	29a. Certifier	1 X Certifyin	ng Physic	cian: To the best	of my kno	wledge,	death o	occurred at the	time, date	and place	, and due to th	ie cause	e(s) and manner a	s stated.	
	ica	(check only one)	2 Medical	Examine	er: On the basis of and manner st	f examina	tion and	l/or inve	stigation, in m	y opinion,	death occu	irred at the tim	e, date	and place, and du	ue to the cause(s)	
	ĭ Ze	29b. Signature and	d title of certifier	r /					29c. Lice	nse numbe	er		29d. [Date signed (Mon	th, Day, Year)	
		1	1/1	1					2-1	C (1)	22		-	7.0	2 2011	
	ŀ	Car.	Mary 16	who	malatad causa of	doath (Ita-	m 23a) (Type P		5-0			ju	ine o	LOII	
		30. Name and add	ress of person	wno cor	mpleted cause of	ueam (mer	11 23d) (туре, Р	iiit)		600	North W	olfe	St. Baltim	ore, MD, 21	287
Stat		31. Date filed (Mor.)	32. Registr	ar's Signa	ture 🙎							,		
State stra			JUN 1	3 20	11 Den	we	A.	1	ake							

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Burran Banks		State of Maryland / Department of Health and Mental Hyg 1- For State Certificate of Death Registrar	Reg	201 g. No.	1 1856
Physicia Medical Exami		a Describe Hallo (Nes, Meso, Lee,)	Date of Death Month June 3, 201	Day Year	3. Time of Death 2329 hrs
ricultar Exami		Durran Donnell Banks 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Julie 3, 20	4c. County of Death	1
, see		Johns Hopkins Bayview Hospital Baltimore			
Funeral Director		374387 1/2 M $_2\Box$ F 25 Yrs. Months Days Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. Bir Foreig Co	
ka a		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
. .	ь	MD NA Baltimore			1 Yes 2 No
r 28a-	Director	10e. Street and Number 10f. Zip Code 21814 Crest View Rd. 21839	100	g. Citizen of What Cou	ntry?
s 23a c			ify Yes or No-	14. Race - Amer	ican Indian, Black,
215-0036 be filed within 72 hours after death with the Maryland nital Hyggiene. rleed other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	by Funeral			White, etc. Specify: B/A	ick
hours natur				16b. Kind of Business/	Industry
5-0036 led within 72 Hygiene. other than 'the Medical	Completed	Laborer		Construct	tion
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	8	Timothy Banks Sybil Ja	ckson		
MD 2' d 2 should lth and Mc a 27 is ma numatic c	٤	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura 19b. Mailing Address (Street and Number or Rura 1814 Crest View RD. Bo	al Route Numb	er, City or Town, State	e, Zip Code)
_ 4 9 8 2	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, D		20c. Location - City or	Town, State
Pages 1		4 Doviation 5 Other Specify: Mt. Zion Cemetery 6-11-	-//	Lansdowne	i mb
Baltimore, permit. Pages la Department of He Important: If ite injury or other the		21. Signature of Funeral Service Licensee 22. Name and Address of Facility CACL P. March FIH 276	1 Emdh	The acc B	14 m 2:739
Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re	espiratory arres		Approximate Interval Between Onset and
/Medical xaminer		fullure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot Wounds (2) of Left Shoulder and Thigh			Death
		or condition resulting in death) Due to (or as a consequence of):			
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
d p is	хаш	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
O, e executed sician and burial - transit	edical Examiner	d. UNPENDED X AMENDED Item# 1,per me,g916 6-13-11 sm			
760, cate be physici		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	
Box 6876(c death certificate the attending phy dof for use as the b	Physician/N	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	<i>'</i>	Month [Day Year
by the att	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
F, P.O. lires that the signed by a be detached	Q p		1 Yes	2 No 3 Prot	pably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed		24a. Was an autopsy	y prior to d	topsy findings available completion of cause of
tal Rec	8		perform 1 Yes 2		es 2 No
Vital Rec ysician: The his certificate director, page	å	25. Was case referred to medical examiner? Hospital: Description 26.Place of Death (Check only examiner)		tesidence 6 Other	
ing Phy After th	읽	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28		w injury occurred	
Sion Attendi death. ctor: /	gte	2 Accident Investigation Jun 3, 2011 2255 hrs			D N Cit
Divis	Certification:	3 Suicide 6 Could not be	or Town, Sta		rał Route Number, City nore, MD
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Medical C	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due one)			
To with	₩.	and manner stated. 29b. Signature and title of certifier 29c. License number	- 1	29d. Date signed (Mo	nth, Day, Year)
		O.C.M.E.		June 4, 2011	
X		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	re, MD 212	23	
Sta	ite	31. Date filed (Month, Day Year) 32. Registrar's Signature			
Regist	ar	JUN IO ZUII LENOUP 10. 17			

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			For State	State of Maryland	•				0011	10561	
			Registrar 1. Decedent's Name (First, Middle, La	ct)	Cer	tificate of	Death ————————————————————————————————————	2. Date of Death	eg. No.	ומכמו	
	Physicia Medi		MAXLYNN	ANN BENNE	てて	T		JUN	Day Year	3. Time of Death	
	Examir	ner	4a. Facility Name (if not institution, give	GENERAL (NZPITAL 46. City, Town			or Location of Death		4c. County of Dear		
	Funeral Director		5. Social Security Number 6. S 413 7-8 5518	бех 7. Age (<i>ln yrs. las</i>	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	9. Bir Year) Co	thplace (State or Foreign untry) CAHOMA	
	and show 1 at	5	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits	
	e Maryk r 28a-f : notified	Jirect	MO CARR	OLL E	LNE	es Burg	r			1 Yes 2 □ No	
	s 23a or	Funeral Director	10e. Street and Number	IETT ROAD		21784			og. Citizen of What Co	g. Citizen of What Country?	
5-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	5	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	l I	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto o Specify:	ecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit		
15-0	72 hour n "natu ledical	Completed	15. Decedent's E (Specify only highest g	ade completed)	(Give I	lent's Usual Occu kind of work done O NOT use retired	during most of wor	king	16b. Kind of Business	Industry	
2121	within giene. er thai		Elementary/Seconday (0-12)	College (1-4 or 5+)			JONS AND	ALYST	US GOVE	ENVINENT	
Maryland	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "rtraumatic event, the Mec	To Be	17. Father's Name (First, Middle, Last) OTTO LEG				18. Mother's Nar	ne (First, Middle, M	aiden Surname) GEN SO	A /	
aryl	nd Me s mark		19a. Informant's Name/Relationship (1		19b. Mailin	ng Address (Street			City or Town, State, Zi		
	and 2 sl Health a tem 27 i			TT/HUSBAND			TTRUAD		BUZEMK		
Baltimore,	0 m		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec.	Removal from State	metery, cren	sition (Name of natory or other pla USLL CA		/	20c. Location - City or $\mathcal{NINFIELS}$		
Saltii	permit, Page Department Important: I any injury o		21. Signature of Funeral Service Licen		22	. Name and Addr	ess of Facility	V ZumBA	WW FHE 1	nov Co	
	20 E 20			imbrun						126-MS 21764	
	nysician/	i s	shock, or heart failure. List only of Immediate Cause (Final disease or condition	plications that caused the death, one cause on each line.			ing, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death	
	Medical Examiner	ı	resulting in death)	Due to (or as a conseque						30 DAYS	
	n #	Examiner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque							
	be executed sician and burial-transit	Exan	Cause (Disease or ilinjury that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):						
09/	ate be e	edical		d							
. Box 6876	or Attending Physician: The law requires that the death certificate by after dath. Iffer dath. Incorp.: Alter this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the the transmission.	Physician/Medi	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▲ No g □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnar Other (specify)	23d. Date o		elivery Day Year		
P.O.	s that the	by Pł	Part II. Other significant conditions of		Iting in the u	nderlying cause g	iven in Part I.		acco use contribute to		
rds	v requires the been signer should be	eted	KWTE ROWA	2 FARWILL				1 Ye		Probably 4 Unknown	
Division of Vital Records,	The law cate has page 2 s	Completed						autops perform	y prior to	completion of cause of	
ita	nysician: The nis certificate I director, pago	Be	25. Was case referred to medical examiner?	Hospital:			Place of Death (Chec	ck only one)			
) t	r this or	일:	1 ☐ Yes 2 ☐ NNo 27. Manner of Death	1 Inpatient 2 E	R/Outpatien 28b. Time of	nt 3 🗆 DOA	4 ☐ Nursing H	ome 5 Resider	nce 6 Other (Spec	cify)	
ion	Attending I death. ctor: After y the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not b		injury	wor	rḱ? ☐ Yes 2 ☐ No				
Divis	ital or Attendurs after deathal Director; /		4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,	
	To the Hospital of within 24 hours at To the Funeral D completed filled in	Medical	(Check 2 Medical Exam	sician: To the best of my knowled iner: On the basis of examination a se Practioner: To the best of my l	and/or invest	tigation, in my opin	ion, death occurred	at the time, date and	place, and due to the	cause(s) and manner stated.	
1	Vithii Comp	-	29b. Signature and title of certifier	ayou		29c. Licens			d. Date signed (Mont	h, Day, Year)	
			30. Name and address of person who	completed cause of death (Item 2		nnt)				11, 2011	
0			DAVID O. NYA	FOI Pun most	10 CH	ANTON (Ja 12 310	whome	12 ms 20	544	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	FAR						

\X DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month **A**Day : 30 A M James E. Barley Tune Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country)
 TTA **Funeral** Months Days Min. May 22,1935 1 M 2 F Director 219-32-2764 76 VA. Usual Residence of Decedent 2 should be filed within 72 hours and the and Mental hygiene.

27 is marked other than "natural", or items 23a or 28a-f show the went, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1√2 Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1517 E. North Ave. Apt. 204 21213 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 Yes 2 No
If Yes, Give
Year or Dates. ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver <u>Graybar Co</u> any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Robert Barley Rena Beck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Ronshay Chisolm daughter) Baltimore, High St. Balto.Md 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt.Zion Cem. Juhe 14,2011 Balto, Md 21. Signature of Funeral Service Licensee Calvin B. Scruggs funeral Home Preston St. Balto.Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between ?hysician/ Immediate Cause (Final Onset and Death Jeps5 disease or condition resulting in death) week Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 Pregnant at time of death Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Nuknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A:
completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 6/4/2011 2438 946 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimorp MD 21218 University Parkwar Rona 2ο 31. Date filed (Month, Day, Year) 3 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 18563 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 2011 10:00 AM Enid Betty Cweiber Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery The Ring House Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Sep. 14, 1928 1 🗆 M 2 🛛 F Hours Australia **Director** 82 216-30-5446 Usual Residence of Decedent 28a-f shov 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 IISA 1801 East Jefferson Street # T19 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. Completed 3 x Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be laryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Dora Cohen Gordon Segal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11621 Twining Lane, Potomac, Maryland 20854 Department of Health a Important: If item 27 is any injury or other trai Linda Abel, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/10/2011 Olney, Maryland Judean Mem. Gardens 4 Donation 5 Other (Specify) 22. Name and Address of Facil dward Sagel Funeral Direction, Ind. 21. Signature of Funeral Service Licenses > MCGreenhat MOIS97 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ cal diomyopatny disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Division of Vital Records, P.O. Box 68760 Cause (Disease or iinjury that initiated events myelodysplasi a attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabeta mellitus -2 1 Yes 2 No 3 Probably 4 Unknown Hypotension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No 101 Other: 4 \(\text{Nursing Home} \) 1 Nursing Home 5 Residence 6 \(\text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Investigation ☐ Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69568 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1801 E Jeffenon St, Pockville, MD 20852 A-chilakamam, MD 31. Date filed (Month, Day, 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Augustus Istadio Month **Physician** 0410 2011 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1**X**M 2□F Months Days Hours 115-30-664 New **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b Counts 10c. City, Town or Location 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director TUNKHANNOCK 10g. Citizen of What Country? ò 1865 or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 □ No If Yes, Give Year or Dates: MACINES 14 Bace - American Indian 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White 2 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than JewelRi 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental ၉ OMINIC 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra lichael TUNKHANNOCK, PA 18657 reld 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Pages 1 Date 1 🔀 Burial 2 🗌 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service CONKING Part 1. Enter the disease, or shock, or heart failule. List Approximate Interval Between Onset and Death cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Pulsaless Elutica **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner etabolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit the death certificate be executed and Due to (or as a consequence of): attending physician Box 68760, Physician/Medical the as IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Yes 2 □ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month. Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After 5 Pending investigation Injury or Attending 1 Natural Accident 1 🗌 Yes 2 TNo 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar DHMH 17 Rev 1/2001

32. Registrar's Signature Date filed (Month, Day, Year)
UN 13 2011

Sourik

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chatterjee

RES-000

JUNE 0

600 North Wolfe St, Baltimore, MD, 21287

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician UNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Court Anne ARunde LOYKIAM LOYBIAN MARY/And 7. Age, (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days Hours 13-88-3992 1**X**M 2□F Wember 29 1961 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show ? is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notifiled at 1 Xes 2 No Director mod 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 142 A COUR 107/1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ HMERICAM 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Worker 124 12 should be filed with and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an ant; If Item 27 is ury or other trau BEHR 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important; If It any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State June 18,2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Arress of Facility
NAMELY M. WALLACE 21. Small re of Funeral Service Licu see FUNCKAL 21229 3405 (D. FRANKlin St. 23a. Park Enter the dis shock, or hear fail Immediate Cause Mal Approximate Interval Between Onset and Death sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. Physician stage mo disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner tepatitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to force a consequence of Examiner Alcaholism use as the burial-tran and Due to (or as a consequence of): Box 68760, attending physiclan certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the all d be detached for P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Sier or Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy performed? Yes 2 No 1□ Yes Physician: 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending Platter death.

I Director; After to 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nd address of person who completed cause of death (Item 23a) (Type, Print) 32. Regisfar's Signature Niewenhou 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day CATHERINE TIINE 0 Medical LILLIAN 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Security Number 1 Year If Under 24 Hrs. a of b.. onth, Day **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Months Days Hours Min Country) Maryland 88 Director 220-34-0372 1923 Apr. Usual Residence of Deceden 28a-f show 10b. County 10a. State with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Frederick 1 Yes 2 XNo Maryland Woodsboro 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 11304 Creagerstown Rd. 21798 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 XNo Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 X No Specify "natural", 3 XWidowed 4 Divorced Specify Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 8 rubber co. factory worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ James Franklin Curry Fannie Delaughter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mary Ellen Crum/ daughter Frederick St. Walkersville, MD 21793 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Mt. Hope Cemetery 6/13/2011 Woodsboro, MD 21. Signa ore of Furtheral Service Licens 22. Name and Address of Facility Hartzler Funeral Home atharine Main St. Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Inijury that initiated events Due to (or as a consequence of). Examir -transit Due to (or as a consequence of) resulting in death) Last burialphysician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 the attending IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? o Pregnant at time of death signed by the a 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medica Be completed filled in by the funeral director 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State To the Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 □ 29b. Signature and title of contifier 29d, Date signed (Month, Day, Year) SM Name and address of person who co cause of death (Item 23a) (Type, Print) 185 CM.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sherry Freedma	an	State of Marylar 1- For State Registrar	nd / Departmen Certificate			Menta		Reg	g. No.	201	1856
Physic Medical Exam		Decedent's Name (First, Middle,Last) CLIFFRY TREET TREET	36437			_			Day	Year	3. Time of Death 1840 hrs
NICUICAI LAAIII	mer	SHERRY FREED 4a. Facility Name (if not institution, give street and num		14	b. City, Town, or Lo	ocation of D		lune 8, 20		ounty of Deat	
		201 N. Spring Court	,		Baltimore				1	N/A	
Funeral		Social Security Number 6. Sex 7.	Age (In yrs. last birthda	y)	If Under 1 Year	If Under 2	4Hrs.	. Date of Birth	(MM/DE)/YYYY) 9. Bi	rthplace (State or
Director		219-70-6032 1 M 2 X F	M 2XF 55 Yrs. Months Days Hours Min.					12/29/1955 Foreign Country) MD			
_		Usual Residence of Decedent									
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ith the Maryland 23a or 28a-f sbo notified at once.	Director	10e. Street and Number			10f. Zip Code			100		n of What Cou	ntry?
15-0036 filed within 72 hours after death with the Maryland Hygiene. 23 other than "natural", or items 23a or 28a-fahe 5, the Medical Examiner must be notified at once		201 N. SPRING COURT	lent Ever in U.S. 13	Mas	2123 Decedent of Hispa		/ Speci	h, Vac or No.		USA	ican Indian, Black,
eath w itemu	Funeral	1 Never Married 2 Married Armed Ford			s, specify Cuban, N				'"	White, etc.	real filerall, black,
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.003 withi giene.	Completed	12 17. Father's Name (First, Middle, Last)	N	ION:		Matharia	lomo /Fi	rst, Middle, Ma	aidaa Cu	NONE	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C		'REEDMAN		10			rst, Middle, Mi	alden Su	rname)	DEED
212 buld bo Ment mark		19a. Informant's Name/Relationship (Type, Print)		ailing	Address (Street a	FRAN(and Number		I Route Numb	er, City	or Town, State	REED e, Zip Code)
re, MD 2 s1 and 2 shoul fHealth and M ffitem 27 is m		DANIEL CHENAULT/SON	4	71	1 ELSRODE	E AVEN	IUE,	BALTI	MORE	, MD	21214
re, land filters filters friters friters friters friters friters friters friters friters		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from	20b. Place of Di	sposit	ion (Name of ceme	tery,				cation - City or	Town, State
Pages lent of		4 Donation 5 Other Specify:	ANSHE CHAIM	E [C	er place) MUNAH AIT EMETERY	$^{\rm CZ}$ $0e^{-6}$	/10	/2011		BALTIM	ORE, MD
Baltimore, MD 21215, permit. Pages I and 2 should be filed Department of Health and Memal His Important: Witem 27 is marked of injury or other traumatic event, the	1	21. Signature of Funeral Service Licensee		22. Na	me and Address o	Facility					., INC.
	2 5	Heath VVI. Cittle		89	OO REISTE	RSTO	IN R	DAD, P	IKES'	VILLE,	MD 21208 Approximate Interval
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Chronic Due to (or as a co	obstructive	е р	ulmonary	dise	ase				Death
		Sequentially list conditions, b	orisoquerice orj.								
	miner	if any, leading to immediate cause. Enter Underlying Cause	onsequence of):	_							
- 3	am	(Disease or injury that initiated events resulting in death) Last	onsequence of):			_	_		_		
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lox 6876(leath certificate attending phy-	Gar	past 12 months?	1 2 1 t at time of death 5	1	ll death 3 ∟_ er (Specify)	Ectopic pre	egnancy		Mo	onth I	Day Year
Box 6876 e death certificate the attending phy ed for use as the l	hysici	1 Yes 2 No 9 Unknown 9 Unknown		Otri	er (Opecary)						
P.O.	<u> </u>	Part II. Other significant conditions contributing to de	eath but not resulting in t	he un	derlying cause give	en in Part I.		23e. Did tob	acco use	contribute to	the cause of death?
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Vital Rec ysician: The his certificate director, page	BeC	25. Was case referred to medical examiner?			26.Place of		. ,	one)			
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ivisior or Attend after death Director:	gati	2 Accident Investigation	f Injury - At home, farm,	-11				l		Mb a. D.	
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Certification:	determined (Specific)	injury - At Home, lami, s	su eet	lactory, office built	uirig, etc.	201	or Town, Sta		Number of Ru	ıral Route Number, City
Hospit 4 hour Funer: ely fill		4 Homicide 29a. Certifier Certifying Physician: To the best o	f my knowledge, death o	CCLIFFE	ed at the time, date	and place	and due	to the cause	(s) and m	nanner as stat	ed.
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	one) 2 Medical Examiner: On the basis of e	examination and/or invest								
£ .2 £ 8	Me	29b. Signature and title of certifier	/ .	_	29c. License n	umber		1	29d. Dat	e signed (Mo	nth, Day, Year)
•		M	7 10	7	O.C.M.	E.			June 9	9, 2011	
	ł	30. Name and address of person who completed cause									
				00 V	V. Baltimore S	treet, Ba	ltimore	e, MD 2122	23		
Si Regis	ate	31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	_							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Maria Alice Graham 20ÏÎ June 9:40 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth 1 □ M 2 XX Months Hours June 6, 036-20-6243 89 **Director** Newport, RI. Usual Residence of Decedent or 28a-f show notified at iled within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges Forestville 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 6140 Surrey Square Lane #203 20747 U.S.A. an "natural", or items Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: Portugese 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Day care Provider child care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be file of Mental ပ္ Mario Ruby Rose Amelia Pierce and lis ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9903 Sherwood Farm Rd. Owings Mill, Md. 21117 item 27 Jenelle George/Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
St. Columba permit. Page 1
Department of
Important: If it
any injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 17, 2011 | Middletown, RI. 21. Signature of Funeral Service 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd. Clinton, Md. 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions if any leading land cause. Enter Underlying Cause (Disease or linjury the burial-tran that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE use es, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Day Month Pregnant at time of death 1 Yes 2 N à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ 1 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. th (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

URRATTS

the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Division of Vital Records,

White, etc. Specify: black 16b. Kind of Business/Industry self-employed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 1215 Baltimore, 20c. Location - City or Town, State Baltimore, MD 4300 Wabash Avenue Approximate Interval Between Onset and Death 23d, Date of delivery Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed To the Funeral Director: After this certificate has been a completely filled in by the funeral director, page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) æ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene 1 🗸 Yes ဥ 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 28, 2011 30. Name and address of person who completed cause of eath (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Russell Alexander MD. 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar **OCME** 2011 ORIGINAL

0503 hrs

MD

10d. Inside City Limits 1 Yes 2 No

DHMH 17 Rev 1/2001 **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month G Physician/ 12:05 PM Renee N. Geyer 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death General Hospital Mortgomer Olne Montgomer 5. Social Security Number If Under 1 Year / If Under 24 Hrs. Funeral 9 Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 1 🗆 M 2 🏲 F Min. Hours Decnth, D212 Year) 1934 415-52-4311 76 Tefffessee Director Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other thao "oatural", or items 23a or 28a-f sho ral", or items 23a or 28a-f sho Examiner must be cotified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 USA 16808 George Washington Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 2 No 1 Never Married 2 Married þ 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private School Executive Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Carolyn Angel Newman Isa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17508 Gatsby Terrace, Olney, Maryland 20832 permit, Page 1 and 2.
Department of Health an Important: If item 27 is a iniury or other trades Stefanie Warren/Daughther 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Judean Mem. Gardens 1 XBurial 2 Cremation 3 Removal from State 6/10/2011 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Factb}anzansky-Goldberg Memorial Chapels 1170 Rockville Pike, Rockville, Maryland 20852 21. Signature of Funeral Service Licenses magneenhit 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician pirator disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death
Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 又Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy page After this certificate 2 No 25. Was case referred to medical Be the funeral director, 26. Place of Death (Check only one) Hospital 2 🛂 No မ 1 Tes 1x Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number ipleted filled in by 4 Homicide determined City or Town, State) Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) M. A. Mavanur 00071314 9/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

Prince Philip Drive, Olney, Maryland 20832

18101

Manju Arun Mavanur

			Please					-	Are Legible	•	
			For State	State of Ma	aryland / Depa	artment of F <i>tificate of L</i>			7111	18571	
			Registrar 1. Decedent's Name (First, Middle, La	st)	Cer	uncate of t	Jealii	2. Date of Dea	Reg. No	3. Time of Death	
П	Physicia Medio		Daisy V. Handley	•				June	Day Year 8 201	8:30 AM	
-	Examir	er	4a. Facility Name (if not institution, give	•			r Location of Death		4c. County of Dea	th	
			Union Memorial F 5. Social Security Number 6.5		(In yrs. last birthday)	Balt If Under 1 Year	imore If Under 24 Hrs.	8. Date of Birtl	h 0.00	thulan (Ctata au Faurian	
	Funeral Director			M 2 K F 7. Age	84 Yrs.	Months Days	Hours Min.	10/1,5/	26 West	thplace (State or Foreign Dunted) Virginia	
	land show dat	tor	10a. State 10b. County		10c. City, Town or Loc	cation				10d. Inside City Limits	
	28a-f	Director	MD		Ва	ltimore				1 🎖 Yes 2 🗆 No	
	vith the 23a or st be r	ral	10e. Street and Number 3601 Greenvale l	Soad		10f. Zip Code	229		10g. Citizen of What Co	ountry?	
	ems ems	Funeral	11. Marital Status	12. Was Decedent E		Vas Decedent of H	lispanic Origin? (Spe	cify Yes or No-	14. Race - Ame	erican Indian.	
Baltimore, Maryland 21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No	f Yes, specify Cuba □ Yes 2 📈 No	an, Mexican, Puerto I Specify:	Rican, etc.)	Black, Whit		
5-0	2 hour	plet	15. Decedent's E (Specify only highest gr			lent's Usual Occup	ation during most of worki	na	16b. Kind of Business	Industry	
121	oe filed within 72 hours ntal Hygiene. ed other than "natura event, the Medical E.	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	life DI	NOT use retired) Homemake	-	, i	Home		
Q 7	ed ed 등 등	Be (17. Father's Name (First, Middle, Last)	_		пошешаке	18. Mother's Name	(First, Middle, i			
ılan	1 and 2 should be filed w f Health and Mental Hygi item 27 is marked othe other traumatic event, i	오	Oley Dean Smith				Martha				
lan	should and N is ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rura	l Route Number	; City or Town, State, Zi	ip Code)	
≥,	and 2: Health Iem 27		George L. Handle	y Sr. / Hus	-T		le RD. B	<u>altimor</u>	e, Marylan	d 21229	
ore	ge 1 ant of H		20a. Method of Disposition 1. Burial 2 Cremation 3	Removal from State		natory or other plac	ce)	Date	20c. Location - City or		
Itim	it. Pa	- 5	4 Donation 5 Other (Spec	-			ery 6/14		Baltimore irk Funeral	, Maryland	
Ba	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licen	The state of the s	Δ				re, Marylan		
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused						Approximate	
	Physician/		Immediate Cause (Final							Interval Between Onset and Death	
	Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	Caelin	Ц.				
	Examiner	,	Sequentially list conditions.		ul fibri	lation					
	sit sd	Examiner	Sequentially list conditions, y. cause. Enter Underlying Cause (Disease or injury	,	tricula	- D	Huro				
	be executed sician and burial-transit		that initiated events resulting in death) Last	U	consequence of):	ci ica	Procee				
00	e be e ysiciai ie buri	lical		d							
876	tificat ing ph	Med	IF FEMALE:								
Box 68760	Hospital or Attending Physician: The law requires that the death certificate Ly4 hours after death. Funeral Director: After this certificate has been signed by the attending physicated filled in by the funeral director, page 2 should be detached for use as the Little of the funeral director.	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth	If yes, outcome of pregnancy				23d. Date of de Month	*	
P.O.	at the d by 1 detach		Part II. Other significant conditions of	contributing to death be	ut not resulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco use contribute to	o the cause of death?	
S, F	uires the signer of the signer	ed by								Probably 4 🗆 Unknown	
ord	w require s been sign should t	Completed						24a. Was a		utopsy findings available	
3ec	The law cate has page 2 t	mo					and the same of th	autop perfoi 1 🔲 Yes		completion of cause of	
a	iician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?			26. P	lace of Death (Check		220 10 10	0 2 3 110	
Ž	hysic his ce	힏	1 ☐ Yes 2 💢 No		ent 2 ER/Outpatier		er: 4 Nursing Ho	me 5 🗆 Resid	lence 6 Other (Spec	cify)	
n of	ding P h. After t funera	ate:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injur (Month, Day)	y 28b. Time of injury	worl		28d. Describe h	ow injury occurred		
Sio	Atten	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At home, farm, stre			28f. Location (S	treet and Number or Ru	ıral Route Number,	
Division of Vital Records,	oital or urs afte ral Dire			building, etc				City or Tow			
) .	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Exam	iner: On the basis of ex	amination and/or invest	tigation, in my opinie	on, death occurred at	the time, date ar	use(s) and manner as st nd place, and due to the e cause(s) and manner as	cause(s) and manner stated.	
_	To the within 2 To the comple		29b. Signature and title of certifier			29c. Licens	e number	1	29d. Date signed (Mont	h, Day, Year)	
	1-		P Mil	Hasin			438946	Clo	6/8/1	1	
_	0		30. Name and address of person who Mitra Hasher	200	eath (Item 23a) (Type, P	Memor	rial Hox	spital	Baltin	lare, MD	
	Sta Registr		31. Date filed (Month, Pay Year 3	2011 32. Pegistra	r's Signature	faces		\			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ernellas Hernd	-	State of Maryland / Department of Health and Mental H 1-For State Certificate of Death		20	11 1857
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
ledical Exami	ner	Vernellas Herndon	June 6, 20		0835 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 8759 Hayshed Lane Columbia	'n	4c. County of De Howard	eath
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	s. 8. Date of Birth		Birthplace (State or
Director		$2/4$ -64-0906 1 \square M 2 $ otin F$ 57 Yrs. Months Days Hours Mir	MAR 2	4 1954	reign Countrellahama
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
. §	Ļ	mo Howard Columbia			1 Yes 2 No
Maryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What (Country?
ith the Maryland 23a or 28a-f sho notified at once		8759 Hayshed Ln. 81045	1	15A	
ath wit items 2	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S		14. Race - Ar White, et	nerican Indian, Black, c.
fter de	╙	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify:	3/ack
hours a natura	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use rel		16b. Kind of Busine	ss/Industry
36 hin 72 e. than "	Completed	Elementary(Secondary (0-12) College (1-4 or 5+)		St. OF	MD
5-0036 led within 7 Hygiene. I other than the Medica	S		ne (First, Middle, M	<u> </u>	
121; d be fil ental !	BB	Gary Morrison Lois	H. Leu	1/15	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sherramanic event, the Medical Examiner must be notified at once	ဥ	19a. Informa t's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or 1957 1959 Hayshed Life 1968)	Rural Route Numi	per, City or Town, S	tate, Zip Code)
re, MC s l and 2 sl f Health ar if item 27		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City	or Town, State
MOF Pages I nent of It ant: If i			15-11	Lansdou	neimo
Baltimore, permit. Pages I as Department of He Important: If ite	Ī	21. Signifure of Funeral Service, licensee 22. Name and Address of Facility	4- Foodb		
Physician	\dashv	23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Methadone Toxicity and multiple drug			Between Onset and Death
Xaiiiilei		or condition resulting in death) Due to (or as a consequence of):			
	Ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):			
executed an and al - transit		d.			
	edical	✓ UNPENDED ☐ AMENDED 23a,pt.II,27,28a-f,per me,g916	6-23-11	sm	
Box 68760, e death certificate be the attending physicied for use as the buri	MZ.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregn	nancy	23d. Date of deli Month	very Day Year
OX 6 ath cer attendi	Physician/M	4 Pregnant at time of death 5 Other (Specify)			
D. B. t the de by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot	pacco use contribute	e to the cause of death?
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of Vital Records, ng Physician: The law require this certificate has been sineral director, page 2 should be	å	25. Was case referred to medical examiner? [Hospital: 1 Inpution: 2 FR/Outpution: 3 DOA Other, Name N		Residence 6 🗸 0	
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Sion Attendin death ctor: A	Certification:	1 Natural 5 Pending (Month, Day, Year) fd 6-6-11 fd 8:30 am 1 Yes 2 X No	Unknow	n	
Division tal or Attendir rs after death. al Director: A	E L	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, St	ate) 8759 Ha	Rurel Route Number, City
E G D		29a. Certifier Developer Technology Technology Technology	Columbia	,Md.	
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
F 3 F S	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)
		Call Vatur Vell 3 O.C.M.E.		June 7, 2011	
0		 Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore 	ore, MD 2122	3	
St	ate				· · · ·

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

11-04317 Allan Helland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 18573

		n- For State Registrar			Certific	ate of	Death				Reg.	No.		
Physiciai Medical Examin	n/	Decedent's Name (First, Midd Alan Day		llan	d					2. Date of Month June	f Death	ay Year		3. Time of Death 1717 hrs
N.		4a. Facility Name (if not institution 4403 LaPlata Avenue	on, give street and r			T	4b. City, Town, Baltimore		ation of De		<u>'</u>	4c. County of		
Funeral	4	Social Security Number	6. Sex	7. Age	(In yrs. last birt	thday)	If Under 1 Ye		f Under 24h	irs. 8. Date	of Birth/		V/A	hplace (State or
Director		501-13-6440	1 X M 2 F		31	Yrs	Months Da			lin.	02/1	ĺ	Foreig	
	-	Usual Residence of Decedent		L						12/	02/1	919		·· Hai yiali
rath with the Maryland items 23a or 28a-f show any sat be notified at once.	. 1	10a. State 10b. County Maryland N	/A	1	Oc. City, Town Baltin		on							10d. Inside City Limits 1 Yes 2 No
Maryli 28a-f	Director	10e. Street and Number	1.**		Darem	ЮГС	10f. Zip Code				10g.	Citizen of Wha	at Coun	try?
th the		4403 LaPlata A	venue Apt	. L.				1225				U.S	. A .	
ath wi	Funeral	11. Marital Status 1 X Never Married 2 M	12. Was De	orces?			s Decedent of H es, specify Cub					14. Race - White,		can Indian, Black,
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36 in 72 l	Completed	Elementary/Secondary (0-12) O)	ading na				stilled)				
d with	틹	9 17. Father's Name (First, Middle,	N /	A			Depend			ne (First Mic	dle Mai	Depe den Surname)	nde	nt
21215-0036 Juld be filed within 7 Mental Hygiene marked other than ic event, the Medica	as l	Arden Hells							rian		01s			
D 21 hould nd Me is man] 2	19a. Informant's Name/Relations	hip (Type, Print)					eet and	Number o	r Rural Rout	Numbe	r, City or Town,		
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If I filem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at once.	H	Howard V. Hells 20a. Method of Disposition	and (Brot	her)	20h Place o	06 K	no11 Co	urt	Pasa	dena,	Mar	yland 2 Oc. Location - C	112	2
Ore ges 1 ar of H		1 Burial 2 Cremation		rom State	cremate	ory or oth	er place)		"					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Г	4 Donation 5 Other So 21. Signature of Funeral Service	Licensee			22. Na	Cremati	ss of F	acility					e, Maryland
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Physician	1	23a. Part I. Enter the disease, or failure. List only one cause	complications that on each line.	aused the	e death. Do no	t enter th	e mode of dying	, such	as cardiad	or respirato	y arrest,	shock, or heart		Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)												Death
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Division tal or Attendi rs after death. al Director: A led in by the fi			tigation 28e. Plac	e of Injury	- At home, far	m, street,	factory, office	buildin	g, etc.				or Rura	Route Number, City
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Division of Vita To the Bospital or Attending Physicia within 24 hours after death. To the Funeral Director: After this ce completely filled in by the funeral direct Medical Certification: To Ba	100	Check only Certifying Ph	ysician: To the bes niner: On the basis of and manner s	of examina	nowledge, deat ation and/or inv	h occurre vestigatio	nd at the time, d	ate and	d place, an h occurred	d due to the at the time, o	ause(s) ate and	and manner as place, and due	to the	cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 20 Year 455 A BENJAMIN HERMAN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Daltinue N/A tal Da It nuke 4 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 219-22-0551 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 04/16/1927 1 🛛 M 2 🗆 F Months Hours Min 84 Yrs. MD **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location TOWSON 10d. Inside City Limits notified at Director BALTIMORE MD 1 Yes 2X No 10f. Zip Code 21204 items 23a or ner must be n 10e. Street and Number 10g. Citizen of What Country? USA Funeral 21 CHIARA COURT 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or iter dical Examiner Black, White, etc. þ 1 X Never Married 2 Married WHITE 1 ☐ Yes 2 🔀 No Specify: Specify If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be me.
Department of Health and Mental Hygiene.
The state of Health and Mental Hygiene.
The state of Health and Page 1. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2121 College (1-4 or 5+) Elementary/Seconday (0-12) TEACHER AND WRITER EDUCATION Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LAND မ HERMAN LENA MORRIS 19a. Informant's Name/Relationship (Type, Print)
SAMUEL HERMAN/BROTHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 21 CHIARA COURT, TOWSON, MD 21204 Department of Healt Important: If item 2 any injury or other once, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of ANSHEET CHARACTER ANSHED EMUNAH ATTZ Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 06/10/2011 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Henstona bound disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner VICC Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year the should be detached Unknown signed by significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident 5 Pending 1 🗌 Yes 2 **W**No down Steps SULLOWIN Lell Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Seecify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Dire TOWSUM MO DIDON chiaract. To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier сотретер Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) OM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State parks

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G916, 6/13/2011, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JEANNINE Physician/ KEEFER Month 7:07 AM 2011 9 une Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harbon Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year)
Oct 20, Min. Country)
California 1 □ M 2 💢 F Months Davs Hours Director 50 Oct 569-25-1978 196 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho Director 1 Tyes 2 No MD Anne Arundel Curtis Bay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1620 Popland Street United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) is marked other Book Keeper Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Margaret Ellen Siggins Earl Eugene Keefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Driscoll /Sister CA 93614 42552 Deep Forest Drive Coarsegold, injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or other Data 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State June 11Jun 4 Donation 5 Other (Specify) <u>Chesapeake Crematory 2011 2011</u> Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives MO1585 Lockernon 8717 Green Pastures Drive Towson Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): and I-transit Due to (or as a consequence of) resulting in death) Last sician a burial-Physician/Medical ttending physical for use as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months: Pregnant at time of death 1 Yes 2 No by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End-Stage liver disease, Hemochromatosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available Hepa his C autopsy prior to completion of cause of death? performed Yes 2 this certificate 2 No 1 Tes Be 25. Was case referred to medical examiner 1 Ves 2 No 26. Place of Death (Check only one) Hospital: Other: မှ 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director; After it completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation М Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ana RES OOL June, 09,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahalis Sarrafi, MD - 3001 South 3001 South Hanover-Street, Ballimore, Maryland 31. Date filed (Month, Day, Year) 32. Registr State

Registrar

Maryland 21215-0036

Baltimore,

68760

Box

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 Marilyn Kehoe Keating June 11:30 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day January 3 **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min. 1 M 2 X F 577-44-4025 78 Yrs Washington, D.C. Director T933 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ី No Maryland North Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 10301 Grosvenor Place, #909 20852 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates Heating Mary 1 1 Tes 2 X No Specify: 3 Widowed 4 Divorced Specify: White "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 Pepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Modific 2010. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William A. Kehoe Katherine Gainey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10301 Grosvenor Place, #909, North Bethesda, Maryland John C. Keating /Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State June 4 ☐ Donation 5 ☐ Qther (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 2011 21. Signature of Funery 22, Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 23a. Part 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical しひと ちょん //・メクイグ Division of Vital Records, P.O. Box 68760 the attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year عرے Yes 2 9 ☐ Unknown should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? auguend 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 performed Hospital or Attending Physician: The 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🛮 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature d title of certifier 29d. Date signed (Month, Day, Year) 170061302 Kehah 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 8600 Old Georgetown Road, Bethesda, Maryland 20814 Atul Rohatgi, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ethel J. Lomax 6/7/201 4:00pMedical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Baltimore Manor Care-Rossville Essex If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 🕱 F Months Days Min **Director** 579-42-9694 10/5/1934 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at **Funeral Director** 1 Yes 2 No Baltimore Essex 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? 23a USA 21221 8620 Kelso Drive Apt 206B Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ ò 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: black 3 🗌 Widowed 4 🙀 Divorced "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Nursing Facility Supervisor of Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ၉ permit. Page 1 and 2 should be Thelma Coates Freddie Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra once. 6704 Fordcrest Road Baltimore, MD Sheila Jackson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/14/2011 Baltimore, MD <u>-site Cremetory</u> 21. Senature of Funeral Service Licens 22. Name and Address of Facility 4300 Wabash Avenue March Funeral Home West Bsltimore, MD 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year ☐ Pregnant ☐ Unknown Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed' 2 No Yes 2 No 1 Tes Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner To the best of my knowledge, death undered at the time, date and place, and due to the causals) and wanter as state 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 7:00 DM June 019c 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death t.more Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Yes August 13 6. Sex 9. Birthplace (State or Foreign . Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗶 F Min Months Days Hours 159-50-8611 56 Yrs 1954 Florida **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Laytonsville 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 20882 United States 8115 Exodus Drive Was Deceue.
Armed Forces?
Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White Completed 3 Widowed 4 Divorced Specify. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) **5+** the Registered Nurse Hospital Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, thouse. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Page 1 and 2 should be ment of Health and Menta Lillian Wellhofer William Stead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8115 Exodus Drive, Laytonsville, Maryland 20882 Longest /Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Montgomery Crematorium, Inc 1 Durial 2 X Cremation 3 Removal from State June Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, ner Due to or as a consequence of if any leading to immedicause. Enter Underlying Exami signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed page 2 should peen . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? After this certificate 1 🗌 Yes 2 🗌 No ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes Other: 2 M No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man er of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 □ Certifying, Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

22

32. Registrar's Signature

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31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 June 10, 12:00 P M Sylvia Lapins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery National Lutheran Home Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Year
April 22, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2 X F Latvia Director 368-34-1669 99 1914 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Directo 1 Yes 2 X No Fairfax Fairfax Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 22031 3122 Barnard Court death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give within 72 hours after Maryland 21215-0036 1 Yes 2 X No Specify: Specify. 3 X Widowed 4 Divorced Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72. In and Mental Hygiene, 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Hospital Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Made Gobe Augusts Baltgailis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl of Health a fitem 27 is 3122 Barnard Court, Fairfax, Virginia 22031-1905 Aldis Lapins / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite 1 Burial 2 X Cremation 3 Removal from State injury or Montgomery Crematorium, Inc June 12, 2011 Bethesda, Maryland 4 Donation 5 Other (Se 21. Signature of Funeral Service Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850-2805 M00896 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the Approximate shock, or hear e. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician EDENTIA disease or condition STAGIE LNO Medical resulting in death) Due to (or as a consequence of) Examiner REBRO VASC Sequentially list conditions, if any hearing to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a considering of Exami or Attending Physician: The law requires that the death certificate be executed and -tran: Due to (or as a consequence of): y physician ar s the burial-t resulting in death) Last Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death ed by the Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral n 24 hours after death.

Funeral Director; After the funeral filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Munder Aus D0051158 7.0 JUNE 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

DRIVE

ROCKVILLE

MD 20850

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ June 10, 2011 6:50 Roberta S. Laux Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6505 Greyswood Road Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 M 2 🗓 F Hours Min January 20. New York Months 093-20-4197 Director 84 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2X No Maryland Montgomery Bethesda ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 23a 6505 Greyswood Road 20817 United States death \ or items 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other many injury or other. Black, White, etc ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Blanche Coe <u>Charles Holden Savre</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kinnelon, New Jersey 07405 <u>James J. Laux/Son</u> Pheasant Run, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Arlington National Cemetery 4 Donation 5 Other (Specify) June 17, 2011 Arlington, Virginia Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home, Rockville, 300 W. Montgomery Ave., Rockville, Maryland M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death year Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) death certificate be executed use as the burial-trans Cause (Disease or imjury and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo for 4 Pregnant 9 Unknown 5 Other (specify) Month Dav Year Pregnant at time of death sate has been signed by the a page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law certificate has autopsy performed Yes 2 2 No 1 Yes Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 C Other (Specify) Hospital: 1 Tyes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director. 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🚾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one To the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew Poffenroth,

M.D.,

32. Regis

D56652

8218 Wisconsin AVenue #408, Bethesda, Maryland 20814

June 10, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LIEBERMAN ELIZABETH 2°6°11 JUNE 2:07 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death DAYTON c. County of Death HOWARD GLEN HILL ASSISTED LIVING 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 □ M 2 🕅 F Months Hours Min. 579-16-8089 92 6/8/1918 Country) **Director** DC Usual Residence of Deceden items 23a or 28a-f show ner must be notified at filed within 72 hours after death with the Maryland al Hygiene.

Jother than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location DAYTON 10d. Inside City Limits Director MD HOWARD 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 14269 TRIADELPHIA MILL ROAD 21036 n "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 🗓 No If Yes, Give ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: WHITE Specify Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other th: any injury or other traumatic event, the longe. PENTAGON CLERK 12 18. Mother's Name (First, Middle, Maiden Surname) VERABACHICK Be 17. Father's Name (First, Middle, Last) STEIN SARAH မ WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10224 FAIRWAY DRIVE, ELLICOTT CITY, MD 21042 LIEBERMAN/SON WILLIAM Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State KING DAVID MEMORIAL GARDENS 6/10/2011 FALLS CHURCH, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Signature of Funeral Service Licensee May 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease Criminally that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death 5 Other (specify) 2 No signed by the a Id be detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 355 its Living Hospital Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No hours after death. Ineral Director: A Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title o certifier 29d. Date signed (Month. Dav. Year) 2011 who completed cause of death (Item 23a) (Type, Print) 42115 (cdar Date filed (Month, Dav. Year) State **1** 3 2011 Registrar

			Please Type or Print in Black Indelible link. Ensure All Copies A	_
			State of Maryland / Department of Health and Mental Hygie 1 - State Registrer Certificate of Death Registrer	2011 10002
2			Registrar 1. Decement's Name (First, Middle, Last) 2. Date of Death 2. Date of Death	No. 3. Time of Death
hud	Physici: Medi		Jean Elizabeth Myers June 9	Day 2018 12:00 PM
30	Exami		42-Facility Name (if not institution, give street and number) 45. City, Town, or Location of Death Westminster	Carroll County
1	Funeral Director		5. Social Security Number 8. Sex 1	9. Birthplace (State or Foreign Country)
14	3		Usual Residence of Decedent	
	036 s after death with the Maryland ral", or items 23a or 28a-f show Examiner must be notified at	Funeral Director	10a. State 10b. County 10c. City, Town or Location Westminster	10d. Inside City Limits 1 ☐ Yes 2 💆
17	with the 23a or 2	eral Di		j. Citizen of What Country?
5	items	Fun	11 Morital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian,
)	after c	dby	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify:	Black, White, etc. Specify: Place
0	15-0036 72 hours after n "natural", or tedical Exami	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16	b. Kind of Business Industry
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2	Maryl 12 should alth and Me 27 is mar	l y	196. Informant's Name/Relationship (Type, Prittus band) 196. Mailing Address (Street and Number or Rural Route Number, City har les A. Myers, Sr. 820 Amanda Dr. Ne, Westmin	
7	Baltimore, M permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tr. once.		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20b. Place of Date 20b. Place of Disposition (Name of Date 20b. Place 20b. Place of Date 20b. Place of Date 20b. Place 20b. Place of Date 20b. Place	c. Location - City or Town, State
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m.	Balti permit. Departr Imports any inji		21. Signature of Funeral Service Licenses Leene Func Vaugha C. Leene 5151 Balto. National P.	ike (21229)
P	Physician/	Г	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):	
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):	
)	be executed sician and burial-transit	I Exan	Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a consequence of):	
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	587 ertifica ding ph	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	
	ision of Vital Records, P.O. Box 6876C Attending Physician: The law requires that the death certificate or order. After this certificate has been signed by the attending physical physician page 2 should be detached for use as the	Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
	P.O.	by Ph	11000 1 11000000	co use contribute to the cause of death?
	rds require	etec	HIA DEN LE DIA DAMA (A)	24b. Were autopsy findings available
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	Physic This c	은	1 Yes 2 Mo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 27. Manney of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how in	
	nding ath.	icate	1 Watural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation M 1 Yes 2 No	njury occurred
	Division of Vital Records, tal or Attending Physician: The law requires is after death. The law receiver After this certificate has been signed in by the funeral director, page 2 should be	Certif	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, Street)	t and Number or Rural Route Number, tate)
	Division of Vital Rec To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director, After this certificate ha completed filled in by the funeral director, page	Medical Certificate:	29a. Certifier (Check (lace, and due to the cause(s) and manner stated.
	To the within To the сопри	Σ	29b. Signature and title of certifier 29d. License number 29d.	. Date signed (Month, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
	100		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WAYU) A WICKS 7(Z1 Security Boule ward, Windson 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Mill, MD
	Sta Registr		111 1 3 2019 Denem 1. factor	06 [3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ McCracken 8:30 AM ARY CENE 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14042 Tridelphia Rd. Glenelo Howard 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) Director 64 216-48-8372 Feb 23 Usual Residence of Decedent 28a-f show 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Howard Glenelg 10e. Street and Number 10f Zip Code 6 10g. Citizen of What Country? Funeral 23a 21737 United_States 14042 Tridelphia Road items within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 ★ Never Married 2 ☐ Married ρ "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give 3 Divorced 4 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Farming Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) McCracken Gaye Barr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Ron McCracken /Brother 1369 May Road Granite Falls, NC 28630 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl ☐ Burial 2 X Cremation 3 ☐ Removal from State Jun 1 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives MO1585 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Respiratory Physician, Failore Medical resulting in death) Due to (or as a consequence of): Examiner of right lower luns Squamous 41) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical as the l IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year the detached P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Emphysyma. Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law has prior to completion of cause of death? page 2 performed? After this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA . Manner of Death 28a. Date of injury 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A ☐ Accident Investigation completed filled in by the 3
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Notes Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 030573 6-13-11 dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ag Minford 10710 Charter Dr. Suite GO20 Columbia, MD 21044 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Juneth 11, 2011 Glenn S. Myers 5:25 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1XX M 2 □ F July 28, 1934 579 40 6064 76 Director Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Clinton Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 9504 Gwynndale Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? ģ 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XXNo Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) Local #100 Sheet Metal Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Glenn S. Myers Stella Durff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Myers (Wife) 9504 Gwynndale Drive, Clinton, MD 20735 injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place 4 Donation 5 Other (Specify) Lee Crematory June 17, 2011 Clinton, MD permit. 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Figheral Septice Licensee 710 Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on, ach line. Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sequence of burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or attending physician for use as the buria Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did topacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed should should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed , page 2 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 2 🗹 No Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) မှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Man or of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Investigation Accident completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of co 29d. Date signed (Month, Day, Year, Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARY VERONICA ELIZABETH MOORE June 7, 2011 12:15 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2038 Wildlife Drive Windsor Mill Baltimore Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 028-16-5627 1 🗆 M 2 🗶 F July 26, 1923 Massachussetts Director 87 Usual Residence of Decedent 28a-f show 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Windsor Mill Baltimore Maryland 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2038 Wildlife Drive USA 21144 filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: "natural", White Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) US Government Secretary permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any Injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Oscar Raftery Mary Phipps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Flowers (Daughter) 2038 Wildlife Drive, Windsor Mill, Maryland 21244 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory, Inc. Baltimore, Maryland 6/8/11 4 ☐ Donation 5 ☐ Qther (Specify) Signature o Fu Service Licensee Kevin E Fcker 22. Name and Address of Facility McCully-Folyniak Funeral Home, P.A. 21225-1856 237 E. Patapsco Ave., Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 SS IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 12 months? 2 X No Por in the past 12 Month Day Year Pregnant at time of death the 9 🗌 Unknown 9 Unknown P.O. þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4又 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death?
1 Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directions. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Chec 3 [crtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29d, Date signed (Month, Day, Year) D0071287 of death (Item 23a) (Type, Print) . Suite 4105, Balthuere, MO, 21204 31. Date filed (Month, Day, Year) State 3 201 Registrar

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(4a. Facility Name (if not instituti Uppingham 5406 Uppinham Stree	n, give s	treet and nu	mber)		4	b. City, T Chevy		Location of se	Death			4c. County of Montgon			
Funeral Director		5. Social Security Number 554-05-5602	6. Sex	2X F	7. Age (Ir	95	st birthday) Yrs.	If Unde Months	s Day		24Hrs. Min.	-	of Birth(Foreig	hplace (State or n untryCalifornia	
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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene N 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 5.30 x lia 2011 /Medical 4c. County of Death Town, or Location of Death 4b. City 4a. Facility Name (If not institution, give street and number) **Examiner** 7. Age (In yrs. last birthday) More andtown Birthplace (State or Foreign Country) Under 24 Hrs. 8. Date of Birth Month, Pay, If Under 6. Sex 1 M 2 ☐ F Social Security Number **Funeral** Days Min Months 237-01-3683 Usual Residence of Decedent Director 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Pres 2 □ No Be Completed by Funeral Director Timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 007 ennsyl or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 lac 3 ₩idowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) inisher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill Department of Health and Mental Himportant: If item 27 is marked oth any injury or other traumatic even one. McCror taile ျှ Villa 19a. Informant's Name/Relationship (Type, Print) (Friend) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 21201 20c. L. cation - City or Town, State Date 20a. Method of Disposition 1 & Burial 2 Cremation 3 Removal from State 6/13/ Woodlawn Woodlawa 5 Other (Specify) 4 Donation Funeral Home, P.A. of Funeral Service Licensee e and Address of 2222 W. Nor 21216 23a. Part1. Inter the isease, or amplications that ceuted the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List inly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPERTENSIVE CARDIOVASULAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes 28 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: Injury 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0059107 06-08-2011 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE 210 BUSINES CENTER me 31. Date filed (Month) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Romon Martinez 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day May 27, 2011 Komon 1532 hrs Medical Examiner Jase 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 1102 Druid Hill Avenue Apt. # 1405 If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Country) M N Min Months Days Hours 8.16.31 Director 220.28.1796 79 Usual Residence of Decedent 10d. Inside City Limits Ę 1 Yes 2 No MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 21201 HOZ Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No specify: f Yes, Give Year 3 Widowed 4 Divorced <u>a</u> 16a. Decedent's Usual Decupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) nt of Health and Mental Hygiene.

t: If item 27 is marked other than other traumatic event, the Medical Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Be or Bural Route Number, City or Town, State, Zip Code) ဥ 20b. Place of Disposition (Name of cemetery 2 Cremation 3 Removal from State Onation 5 Other Specify nature of Funeral Service Lica art I. Enger the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Approximate Interva **Physician** Between Onset and ailure. List only one cause on each line. /Medical Death a. HASCVD Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Dav Year past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown detached for Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of this certificate has performed? 1 Yes 2 ✓ No death? 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 Yes After t 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 V Natural 5 Pending 1 Yes 2 No Director: d in by the f 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 8, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimpre Street, Baltimpre, MD 21223 Victor Weedn MD JD 31. Date filed (Month, Day, Year) State Registra

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per Htt #26 Per PHY C916 6/13/2011 THE COPIES ARE LEGIBLE. THE ARCHITECTURE OF Many land / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 5 Medical 4a. Facility Name (if not institution, give sheet and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Joseph Richey House If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 6 (Month Days) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2√□ F Director 80 NC 216-32-1777 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 4144 Fallstaff Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Spec Back 3 ▼Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 1 and 2 should be filed within thealth and Mental Hygiens item 27 is marked other the Homemaker House 6th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Lee Andrew Smith Daisey Mae Hayes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 19a. Informant's Name/Relationship (Type, Print) Maxine Garland Bey 3622 Seven Mile Lane apt lF, Pikesville, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 6/6/2011 Woodlawn, Memorial Park of Funeral Service License March F/H West 4300 Wabash Ave, Baltimore, Md 2121<u>5</u> 23a. Par 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical P.O. Box 687 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 \(\subseteq \text{ Yes} \) 2 \(\frac{1}{2} \) No Pregnant at time of death Month Dav Year signed by the a 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 XX ther (Specify Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1/ Natural 2/ Accident 5 \square Pending work 1 Tes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 11. Certifying Physician: To the best of my knowledge, death occurred at the time, gate and place, and due to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month 2. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NORMA JANE PFAFF 10°, 2017 Year JUNE 11:00 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CARROLL COUNTY GENERAL HOSPITAL CARROLL WESTMINSTER Social Security Number 7. Age (In vrs. last birthday If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours 177777924 Director PENNSYLVANIA 215-18-0882 87 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD CARROLL HAMPSTEAD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3654 SHILOH ROAD 21074 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Specify: WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH GRADE HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROLLIN TODD ISABEL WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUDY PFAFF, JR./SON 3654 SHILOH ROAD HAMPSTEAD. MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place PARKWOOD CEMETERY 6/13/2011 BALTIMORE. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, tal 21286 8521 LOCH RAVEN BLVD. TOWSON. and 1. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last as a consequence of): Exam burial-transi Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year ed by the a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records. Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other 은 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1—Natural (Month, Day, Year) injury 5 Pendina 1 🗌 Yes 2 🗌 No Accident Investigation Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier 1 Q Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the f 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29d. Date signed (Month. Day, Year) SO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEHARI, 200 MEMORIAL AVE. WESTMI NSTER

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

1 3 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 201 J Day JOHN POLYNIAK Physician/ June 7, 9:15 A Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Howard Ellicott City Encore at Turf Valley If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Month, Day, Days Pennsylvania 202-09-6493 1 X M 2 | F 92 1919 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Balt.imore 1 K Yes 2 No Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 Funeral 4006 Fifth Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White WW 2 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry
Maryland Department of 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Taxation & Assessments Tax Assessor Be 18. Mother's Name (First, Middle, Maiden Surname)
Barbara Krupa 17. Father's Name (First, Middle, Last) 9 Clement Polyniak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4006 Fifth St.. Baltimore, Maryland 21225 19a. Informant's Name/Relationship (Type, Print, 4006 Fifth St., Baltimore, Maryland Suzanne R. Costa (Daughter) 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Memorial Park 1 🕱 Burial 2 🗌 Cremation 3 🗌 Removal from State Glen Burnie, Maryland 6/11/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kevin E Ecker 237 E. Patapsco Ave., Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and D_vath Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year jo 5 Other (specify) Pregnant at time of death 2 No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed lipage 2 should be det Completed by 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law death? certificate within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 5 Residence 6 Other (Specify) 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 27. Manner of Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) egistrar's Signatu

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2011 3:45 PM June 8 <u>Wilhelmina van de Wall Pohlmann</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Homewood @ Crumland Farms Frederick Frederick If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Social Security Numbe 6. Sex **Funeral** Days 30, Yea Months Hours Min. (Month, 1 □ M 2 💢 F 1919 Washington, Director 92 March 214-32-9713 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No Frederick Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21702 <u>United States</u> 7407 Willow Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by Yes 2 X No Yes, Give 1 Never Married 2 Married Maryland 21215-0036 Specify:White 1 ☐ Yes 2 🔀 No Specify 3 X Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Volunteer Environmentalist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Blanca Crooswijk Willem van de Wall 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1340 Sugarloaf Mountain Road
Dickerson, Maryland 20842 19a. Informant's Name/Relationship (Type, Print) Blanca Poteat/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 20c. Location - City or Town, State 20a. Method of Disposition June 12, 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) 2011 Bethesda, Maryland Name and Address of Facility Funeral Home, Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service License Haran 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Weeks Immediate Cause (Final Physician/ Stroke disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Yea Month 5 Other (specify) Pregnant at time of death ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? p 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Coronary Artery Disease autopsy Jas page 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မှ After this 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A: completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated of properties of the past of (Check only one) 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of June 9, 2011 D35183 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person M.D. 300 West 9TH Street, Frederick, Maryland 21701 Alfrookteh, 31. Date filed (Month, Day, Year)
JUN 13 2011 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician une 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months Days Hours Min. | Month, Day, Obj. 21 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 🗆 M 2 🔀 F Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 Yes 2 □ No Examiner must be notified at 2altimore MD Director 10g. Citizen of What Country? 10e. Street and Number ò items 23a by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Black Baltimore, Maryland 21215-0036 "natural", or Specify: Yes. Give 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education other traumatic event, the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Services and Mental Hygiene. Ace Manager thorade YEAVS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Watsor Shirle Keese, Sr. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore MD 21216 Avenue Nathaniel Briant son Department of Health a Important: If item 27 is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Windsor Mill, MD 1 Burial 2 Cremation 3 Removal from State King Memorial 06/16/2011 4 ☐ Donation 5 ☐ Other (Specify) Jaughin C. Greene Funeral services PVUULT C Seem Fune of Serving Immediate Cause (Fina disease or conditio resulting in death) **Physician** /Medical Examiner Valve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 □ No Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 🗌 No 2 ER/Outpatient 3 🗌 DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: s after death. I Director: After t 5 Pending investigation Injury 1 Natural 1 Yes 2 🗌 No 2 Accident 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 3 Suicide determined City or Town, State) 4 Homicide within 24 hours a

To the Funeral D

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the Hospital 29a. Certifier Medical (check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Barreiro Christopher 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 1 3 2011

DHMH 17 Rev 1/2001

Registrar

parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **JOSEPH** ROTONDO JUNE ANTHONY 2011 10:25 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7815 SHEPHERD AVENUE BALTIMORE PARKVILLE Social Security Number Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D I Months Hours Min (Month, Day, Year, 7/29/1931 MARYLAND Director 215-28-5675 79 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director PARKVILLE 1 Yes 2 X No MD BALTIMORE or 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7815 SHEPHERD AVENUE 21234 USA items death 1 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 1 ⚠ Yes 2 ☐ No 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married ō Completed by within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give WHITE Year or Dates. KOREA "natural" 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) BOARD OF EDUCATION CUSTODIAN 8TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ROCCO ROTONDO MARY BONANNO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORETTA MILLER/SISTER 3016 HISS **AVENUE** BALTIMORE MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) PARKWOOD CEMETERY 6/14/2011 baltimore, md 21. Signature of Funeral Service Link nsee THE JOHNSON FUNERAL HOME, 22. Name and Address of Facility a TOWSON, LOCH RAVEN BLVD. 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a con-equince of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year signed by the a Yes 2 No g Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn certificate Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After 5 Pending work? Natural 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (item 23a) (Type, Print)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** nivorsit 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 🗆 M 2 💢 F Months MARYLAND Director none Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location oermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at **Funeral Director** 1 Yes 2 No timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a 408 31301 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 9 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🜠 No Specify. "natural", 3 Widowed 4 Divorced ack Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) infant infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD skins 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Zion Baptist Church 4 Donation 5 Other (Specify) 11/2011 22. Name and Address of Facility 21. Signature of Funeral Service 6 MN DATUL MO1576 compliquations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 23a. Part 1. Enter the disease, or co shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 🕅 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 X N the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending 1 Tes 2 🗆 No Investigation Could not be Accident Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's State

Registrar

AUG Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month STANFTEL ADINI 201 09:26A 5 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltina If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07-21-1959 Funeral 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days 1 M 2 1 F Months Hours Director 219-70-2512 Usual Residence of Deceden 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location must be notified at Director 1X Yes 2 No MD BALTIMORE ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3524 GREENSPRING AVE. 21211 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th STORE CLERK RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 CHARLES STANFIELD ROSETTA E. HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JASON HAMM-BEY/HUSBAND 3524 GREENSPRING AVE. BALTIMORE, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 06-09-2011 BALTIMORE, MD Sign of re of Fun and Service Lick WILLIAM C. BROWN 1206 W. NORTH AVI COMMUNITY FUNERAL HOME P.A. E. BALTIMORE, MD 21217 AVE. Part 1. Enter the disease. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition neumonia Medical resulting in death) Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the a d be detached for 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icate has been sig 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner?

1/ Yes 2 □ No the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work 2 \(\text{No.} Accident Investigation 1 Yes 6 Could not be within 24 hours after de
To the Funeral Directo
completed filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1/ 🔁 😘 extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature, 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WAN LAME

5

Registrar's Signa

AU417647TC1975

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ James Harry Singleton 2011 5:30 Tune 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. Cheverly Prince Georges Comm Hospital If Under 1 Year | If Under 24 Hrs. | Months | Davs | Hours | Min. 9. Birthplace (State or Foreign 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth Funeral Months (Month, Day, Year) 5-28-31 Country) C 1 X M 2 🗆 F 80 **Director** 250-42-5758 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location aţ 10a. State Director notified Brentwood 1 X Yes 2 No P.G. MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 ms 23a or must be n Funeral U.S.A. 20722 3711- Ouincy Street death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner rmed Forces?

XYes 2 \(\sum_{No} \) No 2/1/5 ō 1 Never Married 2X Married þ 3altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. "natural", Completed 3 🗌 Widowed 4 🗌 Divorced 1/31/5 the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Pepsi Cola Truck Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Edith Hughes James H. Singleton, Sr. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 st
Department of Health ar.
Important: If item 27 is any injury or con-3711 Quincy St., Brentwood, Md. 20722 Mary M. Singleton/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 6/20/11 Cheltenham, Md. Maryland Veteran 4 Donation 5 Other (Specify) Hackett's Funeral Chapel, Hac 814- Upshur Street, NW 20011 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) TE RESPIRATORY FAILURE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying KIDNEY DISEASE Exami Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed -tran and y physician al Is the burial-t Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 I Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 XNo has certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes 2**X** No 1X Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1X Natural 5 Pending 1 🗆 Yes 2 🗆 No Investigation Accident filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) handy fler 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chandras Korapati, M.D. 3001 Hospital Dr. Cheverly, Md.

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)
JUN 13 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene T = For State Registrar Certificate of Death Reg. No. ecedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month tamela Denise Jmith 09:30 AM lune 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospital of Baltimore Boutimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 **Director** Usual Residence of Decedent or 28a-f shov notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore 1 ✓ Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a aulding. 21215 LISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married ō þ 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 No ack "natural" Completed 3 Widowed 4 Divorced ige 1 and 2 should be filed within 72 hours nt of Health and Mental Hygiene. t: If item 27 is marked other than "natur or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) \$9conday (0-12) College (1-4 or 5+) totei Be Maryland Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lircle Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If ii any injury or o cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation / 5 ☐ Other (Specify) ddress of Facility geral Home 270 Feel hilton Bos Balto, Modi 2009 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph_sician/ Endocarditis disease or condition Medical resulting in death) 2 weeks **Examiner** infarcts to spleen, kidners, brean Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Asthma Division of Vital Records, No 3 ☐ Probably 4 ☐ Unknown Intravenous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed? Yes 2. No 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1.X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Cortifying Nurse Fractioner: To the best of my knowledge 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES GOO June 05, 2011 MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATRINA ABADIWA, M.D. 2401 W. Belvedere Avenue HOSPITAL GEBALTIMURE, SIMAI 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State 21215, Darks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Deepdent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician Morton 87 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** None If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 DM 2 F 77 Days 577-46-5913 11/19/1933 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location or 28a-f show notified at 10b. County death with the Marylan 10a. State 1 XYes 2 □ No Director DE Sussex Dagsboro 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō items 23a or ner must be r Funeral 123 Riverview Drive 19939 MGV 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2X No Specify Specify:White þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natur any Injury or other traumattc event, the Medical once. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Store Owner Clothing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isadore Semsker Yetta Dorefsky 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Isadora Lippman Semsker -wife 123 Riverview Drive, Dagsboro, DE 19939 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Gardens 06/13/2011 | Falls Church, VA 22. Name and Address of FacilityEdward Sagel Funeral Direction 21. Signature of Funeral Service Licens 1091 Rockville Pike Rockville, MD 20852 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician neumonio)/Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. From Uniterlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death Live birth 3 Ectopic pregnancy Month Day Year ģ in the past 12 months? 5 Other (specify) d by the at detached f Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 3 2 No 3 Probably 4 Unknown 1 Tes ate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autonsy 1 🗌 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: s after dea h.
al Director After this or 2 No 2 ER/Outpatient 3 DOA 4 \square Nursing Home 6 Other (Specify) 1 Yes 5 Residence မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 🗌 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) filled in within 24 hours af

To the Funeral Di

completely filled i To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) RES-000 lune 9, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 1 Hours MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month SKINNER LEXANDER 1437 011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 🗆 F Junitry) 62 Director 948 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 XNo hmond hesterfie 23a or 2 10e. Street and Number 10g. Citizen of What Country? Funeral 23234 rcle items Was Decedent Ever in U.S. Armed Forces?

1 M Yes 2 □ No If Yes, Give 1/21/71555 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evans Ja nie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Skinner Venice 2701 Circle Chesterfield 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Cemetery 2011 Richmond Faith Funeral Cemetery June 10 2011
22. Name and Address of Facility French Foundations any injury once. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligens Service MDM01576 orings MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL INFARCTION disease or condition resulting in death) WEEKS Medical Due to (or as a consequence of): Examiner HYPERTENSION YFAYS Sequentially list conditions, Directo for as a consequence of than leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Y (AIS that the death certificate be executed GB ESITY and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-YEARS Physician/Medical DIABETES Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 Yes 2X No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 KER/Outpatient 3 IDOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated title of cer 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) HOG6481 5 2011 JUNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOLIMAN COUNTY GENERAL HOSpital 5755 (FRANCIANE, COLUMBIA MED 21044 JASON LEVY, DO MATTHEW 32. Registrar's Agnatus 31. Date filed (Month, Day, Year) State 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day . Year Physician/ MARY 12:15 AM 5CHEMM Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner BAIDMORE BALTIMORE CIT GOOD SAMARITAN HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) Funeral (Month, Day, 1 □ M 2 🕱 F 89 Months Hours 213-18-7204 December 1921 Maryland Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Completed by Funeral Director MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21230 600 Light Street apt433 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 white 1 Yes 2 No Specify. Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mabel M. Miller John A. Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13122 Eastern Avenue Baltimore, Maryland 21220 Kathleen Sweenev niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State June 9, 2011 Brooklyn Park, Maryland Holv Cross Cemeterv 4 Donation 5 Other (Specify) 21. Signature of Furieral S vice Licenses 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 130 East Fort Avenue Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARREST Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner RESPIRATION FAILURE Sequentially list conditions, in any, leading to in mediate cause. Enter Underlying Examiner ECTROLITE DISTURBANCE and -transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last the burialattending physician for use as the hurial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year Day 1 Yes 2 No 9 Unknown the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Anorexia 24a, Was an autopsy performed? Yes 2 No certificate 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Nnpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

KEW CARR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

CARR

2011

31. Date filed (Month, Day, Year)

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6000

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LOCH EM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 18604 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 June 9, P^{M} 7:10 Kay B. Schwartz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda 9. Birthplace (State or Foreign Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min April 26, 1956 1 □ M 2 🗶 F Hours Yrs. Maryland Director 214-70-2623 55 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Montgomery Bethesda 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? ō items 23a or ner must be r Funeral 8101 Maple Ridge Road 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian "natural", or ite Armed Forces? Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the once. Attorney Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Klaud K. Bittner Margaret Louise Hanson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8101 Maple Ridge Road, Bethesda, Maryland 20814 Timothy Schwartz/H<u>usband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Montgomery Crematorium, Inc. 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 13, 2011 Bethesda, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc. tayan 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cance/ eccrime disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2. No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Box been signed by the atte should be detached for Pregnant at time of death Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2. No 3 Probably 4 Unknown Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed 1 Yes 2 No 1 Yes 2 or Attending Physician: 25. Was case referred to medical of Vital director 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death funeral 28b. Time of 28c. Injury at 1 Natural
2 Accident 5 Pending work? Division 2 🗌 No Investigation completed filled in by the within 24 hours after deal To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) # 300 Rochille, MD 20550 50705 MO 9707 Me Lizal Center Dr 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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SCHEOC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death Physician/ wise Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months **Director** 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MDò 10e. Street and Number 10g. Citizen of What Country? 1006 23a Funeral and Mental Hygiene. Was Decedent Ever it U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 Tes 2 No Specify. 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ၉ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a, Method of Disposition Burial 2 Cremation 3 Removal from State 4 Domation 5 Other (Specify) of Funeral Service Licensee 21. Signatu Services 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying Part 1. Enter the disease, or complete and shock, or heart failure. List only one cause on each tine. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) one hour Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine il any, leading to in nocic cause. Enter Underlying Cause (Disease or linjury Due to (or as a nonsequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be defactbed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitys 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ hknown Completed Renal dysfunction Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 ☐ No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JUNE 9, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cause of death (Item 23a) (Type, Print)
3333 North Calvert street suite 555 Balto MD
21218 Shaw N Dhillon MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **JUN 13** Registrar

3:4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Turner Month Joann Year Medical 2011 5100 PM June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6425 Craigmont Road Baltimore 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 😾 F Days Months Hours Min (Month, Day, Year) **Director** 216-80-2372 45 MD Usual Residence of Decedent 28a-f show within 72 hours after death with the Maryland aţ 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified MD NA Baltimore 1 XYes 2 No 'n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 6425 Craigmont 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0 þ 1 X Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify "natural" 3 Divorced Specify: Completed Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than, College (1-4 or 5+) University Elementary/Seconday (0-12) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than the Specialty Hospital 12th grade icensed Practical Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William L. Turner traumatic Marlene Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau DeVaun W. Turner-Son 6425 Craigmont Road, Baltimore, Md 21207 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Donation 5 ☐ Other (Specify) King Memorial Park 6/15/2011 Woodlawn, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Av 21. Signature of Funeral Service Lice and Ave, Baltimore 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Breast Ph sician/ cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, library, real cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a son sequence on): the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 🗹 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 \(\sum \) No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manyer of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 24 hours area with the Funeral Director: Af Accident
Suicide Investigation 1 🗌 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ms Rijapahsem D D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-203 Baltimore MD ZIZOG N.S. Rajapakse, M.D 2835 Smith 31. Date filed (Month 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE Physician/ 4:00 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNES HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Sount) Ciroling 7. Age (in y s. last birthday) 8 Date of Birth **Funeral** Hours (Month, Day **Director** Usual Residence of Decedent or 28a-f show notified at 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 ☐ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 2/22 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 L Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married 2 No Specify: Baltimore, Maryland 21215-0036 1 Tes Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Be Father's Name (First, Middle, Last, Middle, Maiden Surn ၉ 19b. Mailing Address (Street and Number or Rural Route Department of Health ar Important: If item 27 is any injury or other trauonce. Method of Disposition 20b. Place of Disposition (Name of Location - City or Town, State Burial 2 🔲 Cremation 3 🗆 Removal from State 4 ☐ Donation /5 ☐ Other (Specify) 21. Signature of Boneral Servic - Lice Balto MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Small Cancer ¬Physician/ lell nondisease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 Yes 2 2 9 Unknown page 2 should be detached q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 **X**No ၉ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier 1 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) M.D P25485 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVE, BALTIMORE MD-21229 MAMTA SHERCHAN 900 S.

State

Registrar

31. Date filed (Month, Day, Year)

3

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32. Registrar's Signature

18608

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	Physici		1. De	ecedent's Name (First, Middle Allen	, Last)		1	Thon	125		2	2. Date of Dea Month	Day	2011	3. Time of Death
	/Medic Examin		4a. F	acility Name (If not institution,	give street and n	umber)		41	o. City, Town, or	Location of	Death		4c. Co	ounty of Death	
	LAGITIII	Ci	Th	e Johns Hopkins	Hospital			В	altimore	City					
-	Funeral				6. Sex	7. Age (In	yrs. last birti	hday) If	Under 1 Year	If Under 2		3. Date of Birth	Voori	9. Birth Cour	place (State or Foreign
	Director		21	2-40-9707	1 🔀 M 2 🗆 F	7:	L `	Yrs.	onths Days	Hours	Min.	(Month, Day Feb 25			arvland
				al Residence of Decedent											
	anyland show d at		10a.	State 10b. County		10	c. City, Town	or Locati	on						10d. Inside City Limits
	Mar-f sl	访		MD Ba	ltimore			Raic	terstwo	n					1 ☐ Yes 2 🛣 No
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	ns 2 mus	Funeral	11 N	Varital Status	12. Was De	ecedent Ever	in U.S.	13. Was	Decedent of H		in? (Speci	fy Yes or No-	14.	. Race - Ameri	can Indian,
	fter c r iter	교		I ☐ Never Married 2 ☑ Marri	Armed	Forces? s 2 ☐ No Give					Puerto Rio	can, etc.)		Black, White,	etc.
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ş	be filed within 72 hours after death with the Mar tal Hygiane. Id offer than "natural", or items 23a or 28a-f's event, the Medical Examiner must be notified			15. Decedent			16a.	Deceden	t's Usual Occup	oation			16b. Kind	of Business/li	ndustry
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<u>-</u>	hould Me mark	۴	19a.	Informant's Name/Relationsh			19b	. Mailing /	Address (Street				er, City or 1	Town, State, Zi	p Code)
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Baltimore,	permit. Pages Department of Important: If i any Injury or once.]	Signature of Funeral Service L	DA A	and V	1 .				110			stown R	
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				shock, or heart failure. List of	only one cause on	each line.	deam. Do i	iot enter t	ne mode or dyn	ng, such as	cardiac or	respiratory ai	1031,		Interval Between Onset and Death
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):												
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e L	The law ate has t page 2	Completed										autop perfor	rmed?	death?	2 No
<u>a</u>	slcian: The la certificate has irector, page 2	Ö	25.	Was case referred to medical						26 Place	of Death (Check only or		1 103	2
	sicial certif irect	8		examiner? 1 Yes 2 No	Hospital:	Inpatient	2 □ ER/Ou	tnatient	3 DOA Oth	or:		e 5 🗆 Resid		Other (Spec	ifv)
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<u>s</u>	tten deat deat tor; y the	ica	;	3 Suicide 6 Could I	not be 28e Pla	ace of injury	- At home, fa	rm, street	factory, office		28	Bf. Location (Street and	Number or Ru	iral Route Number,
2	I or Attender after death	Certification;		4 Homicide determ	lined bui	ilding, etc. (S	Specify)					City or Tow	ın, State)		
	pital Durs eral filled		29a		g Physician: To t										
	To the Hospital or Attending Physician: within 24 hours after death of To the Funeral Director. After this certification pleiely filled in by the funeral director,	ledical		(check only 2 Medical one)	Examiner: On the and m	e basis of exa nanner stated		d/or inves	tigation, in my	opinion, dea	th occurre	ed at the time,	date and p	place, and due	e to the cause(s)
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	Sta			Date filed (Month, Day, Year)		. Registrar's	Signature	,							
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05 2011 8:03 A M NANCY BEATRICE WHITE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Months Days Min. (Month, Day, Year) 10/19/1927 Hours Director 216-20-6533 83 Usual Residence of Decedent 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 ☐ Yes 2 🏋 No MD HARFORD FOREST HILLS ò 10e, Street and Number 10f. Zip Code ms 23a о 10g. Citizen of What Country? Funeral 1901_COLLETTE CT U.S.A. 21050 "natural", or iteπ ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Completed 3 Widowed 4 Divorced BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ulth and Mental Hygien 27 is marked other the r traumatic event, the 12 SERVICE REPRESENTATIVE TELEPHONE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ WALTER SOMMERVILLE SR. BETTY HUNT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 05/31/2011 Department of Health Important: If item 27 any injury or other tr EDWARD WHITE SR./HUSBAND 1901 COLLETTE CT. FOREST HILLS, MD 21050-2723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BEL AIR MEM. GARDENS | 06-11-2011 | BEL AIR, MD 4 Donation 5 Other (Specify) e of Fune al Service Ligens Name and Address of Facility
I iam Brown Funeral Home-Harford, P.A. 21001 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ NONSHALL CITU LUNG CANCE! disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to or as a consequence of burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical certificate be P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Yes 2 No 9 Unknown 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Ves 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 2 No 1 Yes Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No ၉ 1 Yes 1 mpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D 0028412 PHYSICIAN 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IP NIVATPU ATMOOD ROAD BITC

DHMH 17 Rev 7/2009

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician/ 6/5/201 6:30a Medical Joseph Gerald Walker, Sr 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3609 4th Street Brooklyn 5. Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Months Days Hours Country) 58 9/11/1952 Director 217**-**56-6584 Usual Residence of Deceden 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Baltimore Brooklyn 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3609 4th Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: black 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other transmitted. carpenter Bethlehem Steel 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph V.G. Walker Willotta Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Engle/Friend 3609 4th Street Brooklyn, MD 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Woodlawn Cemetery 6/15/2011 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Funeral Service Lice 4300 Wabash Avenue March Funeral Home West Baltimore, MD 21215 Part 1. Enter the cases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) Medical **Examiner** n-iscle Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran as a consequence of attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year the P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, IM muno depicie 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s performed certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 2 Accident 5 ☐ Pending __Investigation work?
1 Yes 2 No 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0054836 6.10.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. SIVARAW AW 31. Date filed (Month, Day, Balt State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month SUNF Day **Physician** 02.40 A M 2011 Frederick Edward Woodland Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST. AGNES BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1⊠M 2□ F Months 219-16-2728 Director 86 12/23/24 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Director 1 ☐Yes 2 No Md Baltimore Landsdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 Washington Ave. 21227 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 10 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: 2 Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than "n r traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 8 Owner Home Improvement 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file tment of Health and Mental H tant: If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname) Be Otis Woodland Dora Parks 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine V. Woodland / Wife 613 Washington Ave. t: If item 27 Landsdowne, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department o Important; If i any injury or once. 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest VA Ceme. 6/14/ 11 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD. 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or y implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard failure. List of the order of the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA disease or condition resulting in death) FEW DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year isigned by the a 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RESPIRATORY FAILURE, CONGESTIVE 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To o To the Hospital or Attending Physical 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directorial directory. 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Do062634 JUNE 8, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HICKORY RIDGE 20 COLUMBIA MO 21.44 10796 MATIEGN AWAN.MO 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death cedent's Name (First, Middle, Last) 20 Year Physician/ 105 Dara Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 84 Yrs. If Under 1 Year Funeral 1 🗆 M 2 🍱 F Days September 10, 1926Washington, D.C. 578-40-9901 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a, State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 15311 Pine Orchard Drive, #3J 20906 United States within 72 hours after death v 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married White Maryland 21215-0036 1 Yes 2 No Specify: Specify: If Yes, Give Year or Dates. 3 X Widowed 4 Divorced Completed 16b. Kind of Business Industry
Bureau of National 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Affairs Secretary should be filed w and Mental Hygi is marked other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret H. Harvey ၉ James Bullen Latta and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2178 Glenfield Road, Annapolis, Maryland 21401 Larry C. Moore/Son Health tem 27 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Arlington National Cemetery crematory or other place) Arlington National July 21, 2011 Arlington, Virginia Page 1 1 X Burial 2 Cremation 3 Removal from State Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Bethesda, Chevy Chase. Pumphrey Funeral Home/ 7557 Wisconsin Avenue 21. Signature of Funeral Service Licensee M01498 ٠ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ADDY Cardiac Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner typertension Sequentially list conditions, Examine if any, isacing to immediate cause. Enter Underlying thrombosis burial-transit *jei* Cause (Disease or iiniury that initiated events Due to (or as a consequence of): resulting in death) Last ohysician Physician/Medical 20 UCZ the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death use 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Month Day for Pregnant at time of death ed by the a detached for g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page 2 1 Yes 2 M N Yes 26. Place of Death (Check only one) 25. Was case referred to medical director, examiner? Other: Hospital 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After ! injury 1 Natural 5 Pendina 1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Investigation Accident 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50074 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20 Year WILLARD WILTND 4: 40 PM UNE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSP NORTHWES BALTIMORE STOWN Social Security Number 8. Date of Birth (Month, Day, Yea, Jun. 16, 1 Birthplace (State or Foreign Country)
 Maryland If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Days 1 🕱 M 2 🗆 F Months Hours Min 73 Yrs Director 310-40-4451 Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5424 Dogwood Road 21207 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 NO Maryland 21215-0036 If Yes, Give Year or Dates. 1954–62 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 custodian public schools permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Carl Wiland Beulah Metz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21207 Louise Wiland/ wife 5424 Dogwood Rd. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) AllCounty Cremation 6/13/2011 Sykesville, MD Sign of Funeral Service Licer 22. Name and Address of Facility Hartzler Funeral Home attravine 11802 Liberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. THEROSCLEROTIL Immediate Cause (Final Onset and Death Physician CARDIOVASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of). it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events signed by the attending physician and I be detached for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen s 24a. Was an . Were autopsy findings available prior to completion of cause of has autopsy perforn death? after death.

Director: After this certificate 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Certificate: To 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manuer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Medical Examiner: On the pasis of examination and/or investigation, in the opening, seath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 and title of certi 29d, Date signed (Month, Day, Year) EM ddress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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Date filed (Month,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ Month David Woodward. Sr. Merritt June 12:36 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 335 High Falcon Road Baltimore Reisterstown Social Security Number 8. Date of Birth July 9, **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Hours 1 X M 2 D F 1940 Mary land **Director** 212-38-1769 70 Usual Residence of Decedent 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 335 High Falcon Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married Completed by Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Divorced 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Metalergist 12 Black & Decker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of Woodward Dorothy Forsthye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health a if item 27 is Barbara Taylor Woodward Wife 335 High Falcon Road Reisterstown, Maryland 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) All Saints Cemetery 6/14/11 Reisterstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road J. Wayne Osterling Eline Funeral Home Reisterstown, 21136 2.4 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot, or heart silure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer disease or condition resulting in death) Una Medical Due to (or as a consequere of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): nding physician and use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Day signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Arteny 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed COPD 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate 1 ☐ Yes 2 ☐ No 2 1 N To the Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner?
1 Yes 2 Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 🗀 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21136 750 Main St. Reisterstown mp Ohe

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUN 13 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ 8:02 A^{M} 6 <u>Edward S. Zimnawoda</u> June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie Baltimore Washington Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 № M 2 🗆 F Months Hours Min. 111/281/46 Mary Land 218-46-9692 **Director** 64 Usual Residence of Decedent 28a-f show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No MD Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 2 Thomas Road 21060 USA items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces? ò <u>\$</u> 1 Never Married 2 Married Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", res, Give Year or Dates. 1966–68 Completed 3 Widowed 4 Divorced White event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Golf Course Marshall Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ John Zimnawoda Marie Stanton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Maryland 21060 Millie Martin / Companion Thomas Road Glen Burnie 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 Department of Important: If it 1 A Burial 2 Cremation 3 Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) 6/10/11 Glen Burnie, MD. <u>Haven Mem. Park</u> 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Euneral Service Licenses 3620 Wilkens Ave. u Baltimore, Maryland 23a. Part 1. Enter the disease of complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypertensive atherosclerotic cardiovascular disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown been signed by the s should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 X No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 s this certificate has 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner's Hospital Other: 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After work? iniury 1XX Natural 5 Pending 2 🗌 No Investigation Accident 24 hours after deat Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by ☐ Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie

To the H within 2 To the F

Registrar

(Check

only one

ature and title of

Ricardo Csurno 31. Date filed (Month, Day, Year)

3 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) June 6, 2011

29c. License number

D45148

3703 Mountain Road, Suite A-1, Pasadena, Maryland 21122

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month MAY Day Physician/ 2011 9:43 22 ANDERSON ELIZABETH YOURTEE Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan • 23 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign Social Security Number 6 Sex **Funeral** Days Months Hours Maryland Jan. 1926 85 Director 212-24-5756 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State items 23a or 28a-f sho her must be notified at Director 1 Yes 2 X No Thurmont Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21788 United States 8302 Stevens Road death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 9 1 Never Married 2 Married þ Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. Specify:White If Yes Give "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Farming Dairy Farmer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F is marked of ၉ Olive Grace Ahalt other traumatic Leon Ryno Yourtee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 sl of Health a item 27 i 8302 Stevens Road, Thurmont, Maryland 21788 Joel T. Anderson / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o ď 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc.5/24/2011 Frederick, Maryland. 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Displayers) Examir burial-transit Cause (Disease or imputhat initiated events resulting in death) Last and iding physician Physician/Medical certificate be Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 🗌 Yes 2 🔲 No 3 Probably Unknown Division of Vital Records, Completed page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performe death? 1 ☐ Yes 2 ☐ No this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Certificate: To Be examiner? Other: 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of njury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After iniury 5 Pending Natural
Accident 2 🗌 No Investigation 3 Suicide 4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after determined within 24 hours To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29a. Certifier

only one) 29b. Signature and title of certifi

th, Day, Year

5

cause of death (Item

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

400 West 7th Street, Frederick MD 2170

11-04203 Milton Adams Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Milton Adams		1- For State Registrar		of Maryla	_	artment c rtificate c			Mental F		Reg. No.	201	1 18617
Physicia Medical Examin	-	1. Decedent's Name (Find MILTON)	irst, Middle,Las	t)	AI	DAMS				2. Date of De Month June 4, 2	Day	Year	3. Time of Death 1436 hrs
		4a. Facility Name (if not 8275 Jacksont		e street and nur				Town, or Le	ocation of Dear		4c. Co	ounty of De	ath
Funeral Director		5. Social Security Number 219-34-78	827 1 <u>X</u>	ex]M 2 ☐ F	7. Age (In yrs.	last birthday)	Mont	der 1 Year hs Days	If Under 24Hi Hours Mi		irth(MM/DD	C.	Birthplace (State or eign MD
Maryland 28a-f show any d at once.	ō	MD	CHARLE	s		, Town or Loca	Y						10d. Inside City Limits 1 Yes 2 X No
ith the Mary	al Director	10e. Street and Number 8275 JACI				IS 142 W		p Code 20662				. s.	Α.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traunatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 3 Widowed	4 Divorced	Armed Fo 1 Yes If Yes, Give Year or Dates:	2 X No							White, etc.	IITE
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Baltimore, cernit. Pages 1 ar Department of Hee Important: If ite Injury or other tr	ļ	1 XX Burial 2 0 4 Donation 5 0 21. Signature of Fungra	Other Specify:		m State NA		BA	P.CEN	ME. 10	, 2011			YICE, P.A.
Physician		Jown 10 23a. Part I. Enter the dis	sease, or compl	Sub- lications that ca	M00	641 56	35	WASH	INGTON	AVE.,	LA P	LATA,	MD 20646 Approximate Interval
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Division of Vital Records, P.O. Box 68760, ospital or Attending Physician: The law requires that the death certificate be executed hours after death. Ineral Director: After this certificate has been signed by the attending physician and ly filled in by the funeral director, page 2 should be detached for use as the burial - transity filled in by the funeral director, page 2 should be detached for use as the burial - transity of the state of the page 2 should be detached for use as the burial - transity of the state of the page 2 should be detached for use as the burial - transity of the state of the page 2 should be detached for use as the burial - transity of the state of the page 2 should be detached for use as the burial - transity of the state of the page 2 should be detached for use as the burial - transity of the state of the page 2 should be detached for use as the burial - transity of the state of the page 2 should be detached for use as the burial - transity of the state of the page 2 should be detached for use as the burial - transity of the state of the page 2 should be detached for use as the burial - transity of the state of the page 2 should be detached for use as the burial - transity of the state of the page 2 should be detached for use as the burial - transity of the state of the page 2 should be detached for use as the burial - transity of the state of the page 2 should be detached for use as the burial - transity of the state of the page 2 should be detached for use as the burial - transity of the state of the page 2 should be detached for use as the burial - transity of the state of the page 2 should be detached for use as the page 2 should be detached for use as the page 3 should be detached for use as the page 3 should be detached for use as the page 3 should be detached for use as the page 3 should be detached for use	Pnysician/N	3b. Was decedent pregress 12 months? 1 Yes 2 No 9		1 Live bir	th nt at time of de	2 Fe	tal death		Ectopic pregn	ancy	Mo		Day Year
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<u>ï</u>	Page nent ant: Ir ury or		1 ☐ Burial 2 XCremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from State pecify)	7			on Inc	5/24	/2011	Han	pste	ad, 1	Maryland
Baltimore,	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service L	censee				Address of Fac hington						napel, PA 21157
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. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	of pregnar 2 Fetal at time of de	ncy death 3 eath 5	Ectopic pre Other (spec					23d. Date Mon		ery Day Year
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Division of Vital Records,	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate his completed filled in by the funeral director, page	Certificate:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	not be			M et, factory, o	1 Yes 2		8f. Location (S City or Tow			or Rural	Route Number,
	Hospita 24 hours Funeral sted filled	Medical	(Check 2	Physician: To the best of kaminer: On the basis of e	examination	and/or investig	gation, in my	opinion, death	occurred at t	he time, date a	and place	e, and due	to the cau	se(s) and manner stated
	o the		only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	best of my	knowledge, de	eath occurre	d at the time, da	ate and place	and due to th	ie cause(s) and mar	ner as sta	ited.
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	MJL 5		30. Name and address of person v	/n·U·	leath (Item	23a) (Type, Pr		- 0 / 0 -		1	MAL	721,	4011	
	5		DAME SUFFREDIN					Her 22.	South GR	GENE ST.	BAL	TIMORE	UM.	21261
	Star Registra		31. Date filed (Month, Day, Year) MAY 9	32. Registra	ar's Signatu	ire	and I	,					1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 4 Physician/ Beazley 15 15 PM May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** COUNTY GENERAL HOS OLUMBIA HOWARN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 20,1922 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 F Hours 284-14-0434 **Director** 89 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Howard Glenwood 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14501 MacClintock Drive 21738 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

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1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death 9 Unknown P.O. signed I I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 **X** No Records, 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 N page this certificate rector, Be 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 5 Pending 1 Natural To the Hospital or Attendia within 24 hours after death. To the Funeral Director: All completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death assumed at the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 508 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdo atricent 10910 State

DHMH 17 Rev 7/2009

Registrar

					it in Black I aryland / Dep				i Are Legible	
		_	For State Registrar			rtificate of		F	Reg. No.	18620
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Ernest A. Bavar					2. Date of Dea Month 5	Day 28 Year	3. Time of Death 6:56 P M
	Examin	er	4a. Facility Name (if not institution, give s Gilchrist Hospie				or Location of Death D lumbia		4c. County of De.	_
	Funeral Director		5. Social Security Number 6. Sex 199–09–9973	7. Age	(In yrs. last birthday) 91 Yrs.	If Under 1 Yea Months Days		8. Date of Birth		irthplace (State or Foreign ountry) PA
	nd how at	,	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryla 28a-f s otified	Director	MD Howard		Ellicot					1 🗆 Yes 🗶 🗀 No
	with the 23a or ust be n		10e. Street and Number 9506 Joey Drive			10f. Zip Code 21042			10g. Citizen of What C USA	Country?
920	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	ed by Funeral		12. Was Decedent E- Armed Forces? 14 Yes 2 1 If Yes, Give Year or Dates.	ver in U.S. 13.	Was Decedent of If Yes, specify Cult	Hispanic Origin? (Sp ban, Mexican, Puerto lo Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
15-0	2 hour	Completed	15. Decedent's Edu (Specify only highest grad	ucation	(Give	edent's Usual Occu	e during most of wor	king	16b. Kind of Busines	s Industry
21215-0036	within 7 giene. er than the M		Elementary/Seconday (0-12)	College (1-4 or 5-	+)	00 NOT use retired //ajor	a) 		US Army	
Maryland	should be filed within and Mental Hygiene. is marked other tha raumatic event, the I	To Be	17. Father's Name (First, Middle, Last) Joseph Bavaria				18. Mother's Nar Jenny	ne (First, Middle, M Tarsi	Maiden Surname)	
Man	1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Typ			0			City or Town, State, 2	
ē,	of Heal of Heal fitem		Maria Fiorelli/ da 20a. Method of Disposition 1 Burial 2 **Cremation 3 F		20b. Place of Disp			Date	20c. Location - City of	
Baltimore,	t. Page tment tant: I		4 ☐ Donation 5 ☐ Other (Specify)		Ardent C	rematory	6/2/		Hanover,	
Bal	Depar Impor any in		21. Signature of Funeral Service License	homa	M00957					mily FH Inc. tv, MD 21043
F	Physician/ Medical		23a. Part (Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	PROB	ABLE B				est,	Approximate Interval Between Onset and Death
Agent and	Examiner	L	Sequentially list conditions,	Due to (or as a	consequence of):					
	ed nsit	Examiner	if any, leading to immediate cause, Enter Underlying Cause (Disease or iinjury	Due to (or as a	consequence of):					
	ath certificate be executed attending physician and for use as the burial-transit	<u>a</u>	that initiated events resulting in death) Last		consequence of):					
8760	ificate big physical as the b	Medic	IF FEMALE:	d						
. Box 68760	or Attending Physician: The law requires that the death certificate by after death. After death. The death. The continue has been signed by the attending physis in by the funeral director, page 2 should be detached for use as the the transfer of the control	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 Fetal death 3	☐ Ectopic pregna ☐ Other (specify)	ncy		23d. Date of d Month	elivery Day Year
P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions con	-						to the cause of death?
ords	require been si should I	leted	CHRONIC MY	ELIGEN	ious Le	uncilli	17	1 □ Y		Probably 4 Unknown
Reco	sician: The law is certificate has birector, page 2 s	Completed by						autops perfor 1 \sum Yes	med? death?	es 2 No
ital	ysician: is certific director,	Be	25. Was case referred to medical examiner? 1 Yes 2 N No	ospital:		01	Place of Death (Checkher:		· branca	ecity) HOSPICE
of V	ng Phys ter this neral di	te: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of injur (Month, Day,		of 28c. Inju	4 L Nursing H		ence 6 COther (Special Other Other (Special Other Other (Special Other Other Other (Special Other Othe	ecity) HUST C
Division of Vital Records,	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injui	ry - At home, farm, so (Specify)	M 1	☐ Yes 2 ☐ No	28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
Δ	To the Hospital of within 24 hours at To the Funeral D completed filled in	Medical	29a. Certifier (Check 2 Medical Examinonly one) 3 Certifying Nurse	er: On the basis of ex	amination and/or inve	stigation, in my opii	nion, death occurred	at the time, date ar	nd place, and due to the	e cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	500	1	29c. Licen	ise number	2	29d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who co	impleted cause of de	eath (Item 23a) (Type.	Print)	4395		MHY Z	8,2011
5	5+		DANIEUE DOBERM	AN, MA	6336		R LANE	COLL	LMBIAIN	10 21044
	Stat Registra	te ar	31. Date filed (Month, Day, Year) MAY 3 1 20	32. Registra	's Signature	barre				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year EMMETT CHARLES, BRANDT YAM 1424 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL HOSPITA COLUMBIA HOWARD 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F Months Hours 217-18-1814 08/25/1923 Director 87 Usual Residence of Decedent show should be filed within 72 hours after death with the Maryland and Mental Hygiene.
is marked other than "natural", or items 23a or 28a-f shov 10a. State 10c. City, Town or Location must be notified at Director 10d. Inside City Limits 1 Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7928 James Avenue 21043 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc." Black White etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify. Year or Dates. 1943-46 White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Food & Beverage 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Brandt Wilhelmina Prieber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 st ment of Health a ant: If item 27 is Millicent E. Brandt - wife 7928 James Avenue Ellicott City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State st. John's Luth. Cem. 05/31/2011 Columbia, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign to re of Funeral Service Lig 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc ianita 4112 Old Columbia Pike Ellicott City, MD 21043 M00957 Thomas 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) PROBABLE SUPPEN CARDIAC Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine it any teading to immedicause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 No 9 Unknown cate has been signed it, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 VER/Outpatient 3 IDOA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 6 Could not be Suicide within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifi 29c. License number 29d, Date signed (Month, Dav. Year) M 77760 1106 25 YAM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Albreht 585 G S4.5E Apt 13 Washington DC 20003

DHMH 17 Rev 7/2009

State Registrar distrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MAY 25 Physician/ 2011 FREDERICK EDWARD BRAMWELL 2219 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Days Months Hours Min. 577-02-9438 JAMAICA 67 Director Usual Residence of Decedent 28a-f shov 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director notified 1X Yes 2 □ No MD PRINCE GEORGE HYATTSVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ō must be i Funeral 6009 10th PLACE 20782 U.S.A. ral", or items ? | Examiner mus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc þ 1 Never Married 2 Married filed within 72 hours after Specify: BLACK altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates natural" 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4 or 5+) I Hygiene. Elementary/Seconday (0-12) PRIVATE the AUTO MECHANIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever ည FREDERICK BRAMWELL SR MARY JANE S.G. NEALOREY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i GARY BRAMWELL/SON 6009 10th PLACE HYATTSVILLE, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 5 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 6-19-2011 DOVCOTT CEMETERY SPANISHTOWN, JAMAICA 4 Donation 5 Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME Signature of Juneral Service Lig 7474 LANDOVER RD LANDOVER, MD 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ SEPTIC SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ABSCESS INTRAABDOMINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): burial physician s the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months? for Month Dav 5 Other (specify) Pregnant at time of death the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yes 2 No tal or Attending Physician: The safter death.

al Director: After this certifical led in by the funeral director, p. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No ပ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1X Natural iniury 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5-26-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NABILA KHAN, MD 1500 FOREST GLEN RD SILVER SPRING, MD 20910 MAY 3 1 2011 32. Regis State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 24 2011 Walter H. Barcus 3:09 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Ceci1 E1kton 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 ♣M 2 ☐ F Months Davs Hours Min 03/27/1935 Director 215-32-8572 76 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No MD E1kton Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 84 Charles Street 21921 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11 Marital Status Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White "natural", If Yes, Give 3

▼ Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Walter H. Barcus Laura B. Davis . Page 1 and 2 should be iment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penny Cox - Companion 84 Charles Street, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bethel Cemetery 06/02/2011 Chesapeake City, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 318 George Street, Chesapeake City, MD 21915 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examine herosc Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deedetached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes the Funeral Director. After this contact filled in by the funeral director. မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Matural work? iniury 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 1 only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

12+1 VA

State Registrar 30. Name and addre

(Month, Day, Year) 32. Registrar's Signature

ss of person who complet

cause of death (Item 23a) (Type, Print)

11-03910 Carol Willis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arol Willis	State of Maryland / Departme 1- For State Certifica Registrar	nt of Health and Mental H te of Death	ygiene 20	18621						
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death 0955 hrs						
)	Carol Ann Byington 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	May 25, 2011 4c. County of Dea							
/	Washington Adventist Hospital	Takoma Park	Montgomery							
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birth 218–96–4191 1	Months Days Hours Min	Fore	ign						
	218-96-4191 1 M 2 4 31	Yrs.	06/22/19/9	ountry) MD						
k ar h	10a. State 10b. County 10c. City, Town of			10d. Inside City Limits						
Maryland 28a-f show interes			Lee evi total co	1 Yes 2 No						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f sho injury or other traumatic event, the Molical Examiner must be notified at ment To Be Compileted by Funeral Director	10616 Carter Way	10f. Zip Code 21742	10g. Citizen of What Cou USA	antry?						
r death with or items 23 must be not										
ter deal		1 Yes 2 X No specify:	Specify: Whi	te						
ours aft atural" samine	or Dates:	ecedent's Usual Occupation (Give kind of	work done 16b. Kind of Business							
36 in 72 h han "n lical E	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use ret								
d with ygiene, other there	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 10 Veterinary Technician Animal 18. Mother's Name (First, Middle, Maiden Surname) 18. Mother's									
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Paul Edward Byington	Ruth A	nne Spears							
MD 21 id 2 should alth and Ms m 27 is ma aumatic c		Mailing Address (Street and Number or I 4 Maple Street, Way								
Ce, M I and 2 Health item 2	20a. Method of Disposition 20b. Place of	Disposition (Name of cemetery,	Date 20c. Location - City o							
Pages ent of int: If	1 X Burial 2 Cremation 3 Removal from State Bethe	y or other place) 1 Cemetery 5/2	29/11 Berkeley	Springs,WV						
Baltimore, permit. Pages I ar Department of He. Important: If ite injury or other tr	21 Signature of Funeral Service Licensee	22. Name and Address of Facility	95 Union St	reet						
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not	Berkeley Springs 1 enter the mode of dying, such as cardiac of	wy 25411 or respiratory arrest, shock, or heart	Approximate Interval						
/Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. <u>Cocaine, Oxycodone</u>			Between Onset and Death						
xaminer ِ عُرِ	or condition resulting in death) Due to (or as a consequence of):	did ilipidabolum inc	011100001011							
	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									
aminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	nsequence of):								
tO, e be executed ysician and burial - transit	<u>a</u>									
O, e be execu ysician an burial - tr	x unpended x amended 1 as noted,	23a,27,28a-t,per me	,g918 8-18-11 sm							
tox 6876 eath certificate attending phy for use as the tricical records		Fetal death 3 Ectopic pregna	23d. Date of deliver	ry Day Year						
Box 6876 c death certificate the attending phy ed for use as the hysician/M	1 Yes 2 No 9 V Unknown 9 Unknown	Other (Specify)								
P.O. Besthart the degreed by the educached for by the by the by the by the by the by Physical By Physical for the by Physical	Part ii. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?						
S, P.(Lires that a signed d be der			1 Yes 2 No 3 Pro							
Records, The law requires ficate has been sig page 2 should be Completed				utopsy findings available completion of cause of						
tal Rection: The certificate ector, page	25. Was case referred to medical	00 Bit 10 A B A H 10 A A A	1 ✓ Yes 2 No 1 ✓ Y	es 2 No						
Vital hysician hysician this cert I directo	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Out	26.Place of Death (Check patient 3 DOA Other Nursin	ng Home 5 Residence 6 Othe	эг:						
ing Ph After t funeral	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Ti	me of Injury 28c. Injury at Work?	28d. Describe how injury occurred							
Division (ital or Attending Lars after death, Lars Director: Afferding by the fun	2 Accident Investigation	9:00 am 1 Yes 2 X No	Unknown 28f. Location (Street and Number or R	ural Bauta Number City						
Division of Vital Records, P.(). Box 68760, To the Rospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi edical Certification: To Be Completed by Physician/Medical Es	3 Suicide 6 Could not be determined (Specify) Unknown	n, street, factory, office building, etc.	or Town, State Unknown	urai Node Namber, Oity						
Diving the Hospital or within 24 hours after To the Funeral Diving Completely filled in edical Certif	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat									
To the H within 24 To the Fr completel	one) 2 Medical Examiner: On the basis of examination and/or invand manner stated. 29b. Signature and title of certifier	estigation, in my opinion, death occurred a 29c. License number								
	Quat ?	O.C.M.E.	May 26, 2011	29d. Date signed (Month, Day, Year) May 26, 2011						
	30. Name and address of person who completed cause of death (Item 23a)									
	Ana Rubio MD. Assistant Medical Examiner 900 W	. Baltimore Street, Baltimore, MI	D 21223							
State	11 110 1 5 70 17 7 77 1 17 46 4. 47 4									

	Aı	ner	Plea ded Item 2 per	se Type or Pri Phy 05/23/2 State of Ma	nt in Black Ir 011 Carrol aryland / Depa	idelible Inl L County artment of F	k. Ensure A Will Health and M	All Copies Mental Hyg	Are Legiene	gible.					
			State Registrar			tificate of L		Reg. No. 2011 18625							
	Physicia	n/	1. Decedent's Name (First, Middle	•				2. Wate of Death Month	14 bay	2011 2011	3. Time of Death				
	Medic	al	Perry Resh Coc 4a. Facility Name (if not institution,	-			1 1 1 D - 1	May	5:53 P ^M						
1	Examin	er	Carroll Hospit	al Center		Westmin			4c. Count	oll C	<u> </u>				
	Funeral Director		5. Social Security Number 220–48–3318 Usual Residence of Decedent	6. Sex 1 📈 M 2 □ F	(In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs, Hours Min.	8. Date of Birth (Month, Day,	Year) 1952	9. Birthpl Count Mary					
	laryland 3a-f show ified at	Director	10a. State 10b. County Maryland Carrol	1 County	10c. City, Town or Loc Hampstead					10	0d. Inside City Limits				
	with the N 23a or 2 ust be no	Funeral Dir	10e. Street and Number 4019 Evergreen	Drive		10f. Zip Code 21074			_{0g. Citizen of} Inited						
960	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fun	11. Marital Status 1 ☐ Never Married 2 👿 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 12. Was Decedent 8 Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No I	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bla	14. Race - American Indian, Black, White, etc. Specify: white					
Baltimore, Maryland 21215-0036	within 72 hou giene. ier than "natu i, the Medical	16b. Kind of E heavy equipn		peration											
yland	d be filed Mental Hy arked oth atic event	To Be	17. Father's Name (First, Middle, Last) Melvin Wesley Cooper, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Inez Peregoy												
, Man	id 2 shoul ealth and I n 27 is ma er trauma		9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) elvin Wesley Cooper, Jr./brother 18229 Gunpowder Road Hampstead, Maryland 21074												
more	Page 1 ar nent of He ant: If iter ıry or oth		20a. Method of Disposition 1												
Balti	permit. Departr Imports any inju		21. Signature of Funeral Service L	21. Signature of Funeral Service Licenset M01072 M01											
~ J	Ph, sician/ Medical	Y S	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each line a. CHOKI	the death. Do not ente			or respiratory arre			Approximate Interval Between Onset and Death				
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	i consequence oij.			76.1	3						
	ite be executed hysician and he burial-transit	dical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):		13	3							
. Box 68760	the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. The La hours after death. The Purpural Director: After this certificate has been signed by the attending physicis impleted filled in by the funeral director, page 2 should be detached for use as the burnal director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnand Other (specify)	су			ate of delive	ery Day Year				
ls, P.0	requires that the de been signed by the should be detached	by	Part II. Other significant condition	ons contributing to death b	ut not resulting in the u	nderlying cause giv	ven in Part I.				e cause of death?				
Division of Vital Records, P.O.	sician: The law req certificate has bee irector, page 2 sho	Completed	24a. Was an autopsy findings availal autopsy performed? 1 \(\) Yes 2 \(\) No \(\) No												
ta	cian: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			lace of Death (Chec	k only one)							
<u> </u>	Physi this or	10	1 Yes 2 No 27. Manner of Death	1 🔲 Inpatie	ent 2 ER/Outpatier 28b. Time of		4 ∐ Nursing Ho	ome 5 Reside							
o L	nding tth. : After e fune	cate	1 Natural 5 Pendin	g (Month, Day	Year) injury 1657	work		28d. Describe ho		rea 1 ME	AT				
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	To the vithin To the comp	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)													
	WIL		Bowner northal D30639 5/18/11												
_	1~		30. Name and address of person of BEENA NACIAL		eath (Item 23a) (Type, F BMORIAL		CTALIACETT	TR MID	71157						
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	back			,,,,,						

Physician/ Examiner Box 68760 Records, **Division of Vital**

ms 23a or 28a-f show must be notified at

Examiner

Medical

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"natural"

within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

use as the burial-transit attending physician the ģ neral Director: A 24 hours To the I within 2

> State Registrar

(Check

29b. Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Amend#27.PerPhys.PGC5-31-11 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 2011 Physician/ James Arthur Cooper 26 1320 P^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Prince Georges Community Hosp. Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral** 1**★**] M 2 □ F Months Days Hours Min 03-28-1945 No. Carolina 66 Director 577-60-7724 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No DC Washington, D. C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3516 Clay Place, N.E. 20019 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ☐ Yes 2 🔀 No Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: **Black** Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Truck Driver Briggs Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Arthur Cooper Lucille Lee 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2503 Firehouse Road Landover, Maryland 20785 19a. Informant's Name/Relationship (Type, Print) Isaac Lee (Uncle) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cem. 06-04-2011 Suitland, MD e of F 22. Name and Address of Facility
Ralph Williams, II
5202 PrincetonsDe a 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due o (or a equence of) Cause (Disease or illijury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No page 2 should be detached for Month Day Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Tes 2 No 3 □ Probably 4 □ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this Manner of Deth 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 \square Yes 2 🗌 No Accident Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manger as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) son who completed cause of death (kem 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5 24^{Day} $20^{\text{Year}}1$ Paul Edward Carder 8:29 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 266 S. Washington St. Snow Hill Worcester Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) WV 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2 □ F Hours Min. 89 **Director** 233-30-0725 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 266 S. Washington St. 21863 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white Completed 3 Widowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator Armco Steel Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic avont 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Burton Carder Goldie Houchen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul J. Carder / son 3107 Ryerson Circle, Halethorpe, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

⊠ Burial 2

☐ Cremation 3

☐ Removal from State Eastern Shore Vet. 6/1/2011 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Fart 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Convey Tasufficiency Physician/ acute disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Athenso sciences is Due to (or as a consequence of): P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypercholesterolenia Division of Vital Records, 1 Tes 2 To 3 Probably 4 Unknown Despetes Milletus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 Yes within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D006325 3 Clybe Eracs + Gelet Jr Me. D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 428 West Market St. Snewlf. 11, MD 21863 Ernest 6, 45 Ja M. D. 7 10+1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2011 862												
	Physicia		1. Decedent's Name (First, Middle, Las Faye Lavern Chew	t)				2. Date of De May 21,		Year	3. Time of Death 7:55 а м				
Sagar.	Medic Examin		4a. Facility Name (if not institution, give	street and number)			City, Town, or Location of Death rince Frederick 4c. County of Death Calvert								
	Funeral Director		217-66-2414	7. Age	e (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days			th y, ^{Year)} 9, 1954	9. Birthpl: Countr MC	ace (State or Foreign y) •				
0	nd how at	اۃِا	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation	-			10	d. Inside City Limits				
	Maryland 28a-f show otified at	Director	MD Calvert		Prince Fre	derick					1 🗆 Yes 2 🔀 No				
	h the	alD	10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?						
	ms 2	Funeral	326 Mason Road	12. Was Decedent E	Syor in LLC 12 V	20678	ispanio Origin?	(Specify Yes or No-	USA	A	- Indian				
920	ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho it item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at	β	1 Never Married 2 Married 3 Widowed 4 Divorced		Race - American Indian, Black, White, etc. ecify: Black										
5-0	2 hour	plet	15. Decedent's E (Specify only highest gra		vorking	16b. Kind of Bu	siness Indu	ustry							
2121	vithin 7; iene. r than the Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	itor	Publishin	ıg Co.								
Baltimore, Maryland 21215-0036	2 should be filed within 7 h and Mental Hygiene. 7 is marked other than traumatic event, the M	To Be	17. Father's Name (First, Middle, Last) Leander Chew		Name (First, Middle, Mae Murray	Maiden Surname))								
, Mary	d 2 should salth and N 27 is ma		19a. Informant's Name/Relationship (T) Kelvin C	Rural Route Number	r, City or Town, St ID 20639	ate, Zip Co	ode)								
more	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 Bullet Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	Date by 28, 2011	Date 20c. Location - City or Town, State 28, 2011 Great Mills, MD									
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			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	olications that caused ne cause on each line	the death. Do not ente	er the mode of dying	g, such as card	liac or respiratory ar	rest,		Approximate Interval Between				
-	h sician/		Immediate Cause (Final disease or condition	a. Bre	ast c	ancel					Onset and Death				
	Medical Examiner		resulting in death)	Due to (or as a	a consequence of):						1				
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	a consequence of):										
	be executed sician and burial-transit	Examiner	Cause (Disease Or imjury that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):										
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876	tificate ng phys as the	Med	IF FEMALE:												
Box 687	ath certifica attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal death 3	Ectopic pregnand Other (specify)	Fy .		23d. Date Mor	e of deliver	y Day Year				
). B(that the des led by the a detached f	hysic	1 Yes 2 No 9 Unknown	9 Unknown	t time of death 5 L	Other (specify)									
ds, P.O.	gr gr		Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	nderlying cause giv	ven in Part I.	1	obacco use contri Yes 2 XNo		e cause of death?				
of Vital Records,	The law require ate has been si page 2 should	Completed by							psy prmed? d		sy findings available inpletion of cause of				
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Ξ	Physician: this certific al director,	은	1 ☐ Yes 2 💢 No		ent 2 ER/Outpatien		4 L Nursin	g Home 5 Resid							
0	ling I. After fune	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		ry 28b. Time of injury	28c. Injury work M 1 🗆		28d. Describe l	now injury occurre	d					
Division	tal or Att rs after d al Direct ed in by t														
	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completed filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
	To the within 2 To the comple		29b. Signature and title of certifier	0 -n	442	29c. License		,	29d. Date signed		ay, Year)				
	السرو		30. Name and address of person who d	completed cause of de	eath (Item 23a) (Type, P	rint)	1061	ce frede	-1/24/1	/	20678				
	J K.		Arati Patel 11	O Hospit	al Rd, su	ite 212	Prin	ce frede	inck,	MD					
	Stat Registra		tate 31. Date filed (Month, Day, Year) 32. Registrar's Signature												

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 21 Day A M Mary Elizabeth Cullen May 2011 4:25 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8109 Whirlwind Court Gaithersburg Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Months Days Hours Min. (Month, Day, Country)
Ireland Director 218-38-7410 84 Usual Residence of Decedent should be filed within 72 more.
In and Mental Hygiene.
It is marked other than "natural", or items 23a or 28a-f show.
It is marked other than "natural", or items 23a or 28a-f show.
It is marked other than "natural", or items 23a or 28a-f show. 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Tes 2 X No Montgomery Gaithersburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8109 Whirlwind Court 20882 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hector Wallis Catherine McCartan Jet 1 and 2 sh. Jepartment of Health and Important: If item 27 is many injury or other once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Austin I. Cullen (Spouse) 8109 Whirlwind Court, Gaithersburg, MD 20882 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State 27, All Souls Cemetery 4 Donation 5 Other (Specify) Germantown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gaithersburg, MD 20877 TRACY A MIN M01117 DeVol Funeral Home, 10 East Deer Park Drive, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or s a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 the yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day Year Pregnant at time of death ed by the a detached f 1 Yes 2 2 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy death? Yes 2 No 1 🗌 Yes 2 🗆 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 X Yes 2 □ No Other: ည 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 🛣 No I hours after death. uneral Director: Afted filled in by the fun 1300 M Investigation Mar 22 2011 6 Could not be 3 Suiciae 4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) yd ui pellif palain by 28f. Location (Street and Number or Fural Route Number, City or Town, State) home within 24 hours a

To the Funeral C mo 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifier **Check** 00428 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo, ome

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month; Day, Year)

MAY 25 2011

			For State Registrar	State of Ma		/ Depa		Health and N	/lental Hy		e	18631	
	Physicia	n/	1. Decedent's Name (First, Middle, La	ŕ					Date of Dea Month	ath		3. Time of Death	
	Medic Examin	al	Li Hung-Tao C 4a. Facility Name (if not institution, given 605 Suffield Dr	,				r Location of Death	May 2	4	2011 Year 2011 C. County of Death		
	Funeral Director		5. Social Security Number 6. 215-15-3665		79	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Jan • 2	th y Year)	932 9. Birt Cou Ta	hplace (State or Foreign latry) Iwan	_
	and show 1 at	or	Usual Residence of Decedent 10a. State 10b. County			Town or Loc						10d. Inside City Limits	_
	e Maryl r 28a-f notified	Director	Maryland Montgom	ery	Ga	aither	sburg					1 ☐ Yes 2 🌠 No	_
	with th	Funeral [605 Suffield Dri	.ve			10f. Zip Code 20878	3			Citizen of What Co Ited Stat		
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces?	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give			Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ▼ No Specify:				rican Indian, e, etc. Lan	
Maryland 21215-0036	ithin 72 hou ene. r than "natu the Medical	Completed by	15. Decedent's (Specify only highest of Elementary/Seconday (0-12)		(Give kind of work done during most of working							Industry	
yland 2	d be filed w Mental Hygi arked other atic event, i	To Be	17. Father's Name (First, Middle, Last Tu Lee)				18. Mother's Nam Yeh Yu	e (First, Middle,	Maidei	n Surname)		
	and 2 shoul lealth and I im 27 is ma her trauma		19a. Informant's Name/Relationship Cheng-Kuan Chao	(Type, Print) (Son)				and Number or Rura Dr. Gai	al Route Nymbe thersbu				
Baltimore,	t. Page 1 a tment of H tant: If ite ijury or otl		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	cify)	cen	netery, crem e of H	sition (Name of natory or other plan eaven Ce	m. May 201	. 1	Si	Location - City or		
Bal	permii Depar Impor any in once.		21. Signature of Fungral Service Lice		1116			ess of Facility De eer Park				MD 20877	
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	mplications that caused one cause on each line a. Paralys Due to (or as a	is Ag	itans	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
09,	cate be executed physician and sthe burial to the burial t	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or impury that infitated events resulting in death) Last	Due to (or as a Due to (or a) Due to									
. Box 6876	Physician: The law requires that the death certificate this certificate has been signed by the attending phy ral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 汉 No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal o	death 3	Ectopic pregnan Other (specify)	су			23d. Date of de Month	livery Day Year	
ds, P.O.	v requires that the seen signed by should be deta	ed by Pl	Part II. Other significant conditions	contributing to death b	ut not result	ting in the u	nderlying cause gi	ven in Part I.				the cause of death?	
Division of Vital Records,	sici an: The law rec certificate has be irector, page 2 shc	Completed by							24a. Was auto perfo 1 🖸 Yes	psy ormed?	prior to death?	topsy findings available completion of cause of	
/ital	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 💢 No	Hospital:	0 🗆 5	D/O-ttis-	26. P	lace of Death (Chec			6 Other (Spec	~	_
on of \	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this central process.	Certificate: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigati	28a. Date of inju (Month, Day	ry 2	8b. Time of injury	28c. Inju	y at	28d. Describe			<u> </u>	_
Divisi	ital or Atte urs after de ral Directo		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of Injured building, etc	c. (Specify)		eet, factory, office		City or Tov	vn, Sta			
	the Hosp thin 24 hou the Funer mpleted fil	Medical	(Check 2 Medical Example only one) 3 Certifying Nu	nysician: To the best of miner: On the basis of e urse Practioner: To the	xamination a	and/or invest	tigation, in my opini death occurred at th	on, death occurred a ne time, date and pla	t the time, date a	and place e cause	ce, and due to the e e(s) and manner as	cause(s) and manner state stated.	d
•			29b. Signature and title of certifier	13			29c. Licens D371	42		Ma	Parte signed (Montle ay 23, 20)11	
			30. Name and address of person who Dr, Geoffrey Co			_	_	Suite#10	00 Rock	cvil	lle, MD 2	20850	_
	Stat	te	31. Date filed (Month, Day, Year)		ar's Signatur	e La	del.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

durent Delame		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2011 18632										
Physic ledical Exam		1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death										
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death										
Funeral		1901 Wetherbourne Court Bowie Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or										
Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 1949) Foreign Washington, Country) D. C.										
Any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits										
E.w.	5	Maryland Prince Georges Bowie										
Maryl rr 28a-f	Director	10e. Street and Number 10g. Citizen of What Country?										
5-0036 ed within 72 hours after death with the Maryland stygiene and enter than "matural", or items 23a or 28a-f she the Medical Evandmer must be nedfled at enter the Medical Evandmer and the nedfled at enter		1901 Wetherbourne Court 20721 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,										
or item	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.										
urs after tural",	۾ ا	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry										
36 hìn 72 hou e. than "na	jete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)										
5-0036 led within 72 ho Hygiene. other than "na	Completed	12th grade Night Stock Clerk Safeway Stores, Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)										
21215-0036 und be filed within 7 Mental Hygiene. marked other than ic event, the Medic	Be	Wilbert Herman DeLaine, Sr. Anna Mae Boyd										
MD 2' d 2 should Ith and Ms n 27 is ma	၉	19a. Informant's Name/Relationship (Type, Print) (Wife) Martha Rosetta Salley DeLaine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1901 Wetherbourne Court; Bowie, Maryland 20721										
re, N 1 and 2 Health fitem 3		20a. Method of Disposition										
Baltimore, permit. Pages 1 an Department of He important: If its		4 Donation 5 Other Specify: Olde Miss Cemetery 2011 Smoaks, South Carolina										
Baltimore, MD 21215 permit Pages I and 2 should be file. Departie of File and Amenda by Important: If them 27 is marked by injury or other traumatic event, the		21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.; 600 Kennedy Street, N.W.; Washington, D.C. 2001										
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval										
/Medical Examiner		Immediate Cause (Final disease a Hypertensive Atherosclerotic Cardiovascular Disease Death										
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b										
	niner	if any, leading to immediate Due to (or as a consequence of):										
ted 1 Insit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	fedical	UNPENDED AMENDED										
8760, ificate bong physic		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year										
Box 687 death certific the attending p death or use as the	Physician/I	past 12 months? 4 Pregnant at time of death 5 Other (Specify)										
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?										
of Vital Records, P.O. as Physician: The law requires that the three this certificate has been signed by meral director, page 2 should be detach neral director, page 2 should be detach	ed by	Diabetes Mellitus; Chronic alcohol abuse 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✔ Unknown										
cords aw requals been a shoul	Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of										
Rec The lifticate of Y. page		performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 25. Was case referred to medical 26 Place of Death (Check only one)										
Vita nysician this cer I directo	To Be	25. Was case referred to medical examiner? 1 V Yes 2 No No No No No No No										
# . ~ # I		27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No										
Division pital or Attendio outs after death. ceral Director: A	ficati	2 Accident Investigation 28e Place of Injury - At home farm street factory office building etc. 28f Location (Street and Number or Bural Boute Number City.)										
Div spital o tours aff	Certification:											
Division To the Hospital or Attuvithin 24 hours after des To the Fuoeral Director	Medical											
To To con	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
	İ	O.C.M.E. May 29, 2011										
26		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223										
St	ate											
Regist	trar	HULL O'T FOLL										

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

abend 1 2 per fin Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene 11-04190 John Clyde Dennis, Jr 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month 2155 hrs **Medical Examiner** John Clyde Dennis, Jr. June 3, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Prince George's Mt. Rainier 3304 Perry Street Months Days Hours Min. February 10, 1956 Foreign Alexandria, Country) Louisiana 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Director 220-70-6394 55 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No Mount Rainier or 28a-f show Maryland Prince George's I. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene, retait: If tien 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20712 3304 Perry Street USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 Never Married 2 Married 2 No 1X Yes White 4 X Divorced If Yes, Give Year 1975-1979 1 Yes 2 X No specify: Specify: É 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) BRI, Inc. Baggage Handler Baltimore, MD 21215-0036 12 ASMathers Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Clyde Dennis, Sr. Andrey Arlene Jenkins Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anita L. Dennis / Sister 4307 57th Avenue, #4, Bladensburg, MD 20710 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 6/8/2011 Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Ray Rogers 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and failure. List only one cause on each line (Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. signed by the attending physician and be detached for use as the burial - tra Physician/Medical X UNPENDED #18perFH,G917 Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c, If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Alcohol Abuse Completed 24a. Was an 24b. Were autopsy findings available certificate has been autopsy prior to completion of cause of death? performed? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA After this 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death cation: 1 X Natural 1 Yes 2 No 5 Pending Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be or Town, State) within 24 hours a

To the Funeral I determined Homicide 29a. Certifier (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 4, 2011 O.C.M.E. 30. Name and address of person who complete was eath (Item 23a) Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Jack Titus MD. State 31. Date filed (Month, Day, Year) 32. Registrar's Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 2**0**11 DePalma George Angelo 6:00 a. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Center Prince George's Clinton 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct. 18,1928 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 1 → M 2 □ F Days Months Hours Washington, D.C. 579-34-3616 Director Usual Residence of Decedent 28a-f shov 10a. State 10b County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No Virginia Fairfax Falls Church 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 2005 Edgar Court 22043 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No If Yes, Give Year or Dates. 48–56 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White "natural", Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Produce Manager Grocery Store event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Joseph DePalma Alberta Bricker traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 166, Myersville, Maryland 21773 10532 Church Hill Road 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tra Crystal Edington/niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) May 31,2011 Falls Church, Virginia Donation 5 Other (Specify) Oakwood Cemetery 504 Main Street Signati 22. Name and Address of Facility Myersville, MD 21773 Ricketts Funeral Home Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 51 disease or condition Medical resulting in death) Due t (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami nding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical requires that the death certificate be P.O. Box 68760 es, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year ed by the a detached to 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ s been signe should be d Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an the Hospital or Attending Physician: The law hin 24 hours after death.

the Funeral Director; After this certificate has k page 2 performed 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 XInpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27. Manper of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature ar ٥ 29d. Date signed Max 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Year)

5

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2011 Mäν 16:24 James Ray Douglas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Mary's Hospital Leonardtown 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Social Security Number **Funeral** Sex 1 X M 2 □ F (Month, Months Days Min Hours 70 Washington. Director 577-54-2275 940 Usual Residence of Decedent shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified 1 Yes 2XX No Lexington Park <u>Ma</u>ryland St. Mary's 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral with USA 20653 12766 Princeton Drive death v 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic event. Black, White, etc. 1 Never Married 2 Married ρ 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ret. Navy Construction 12th. Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ္ Marie M. McDermott James A. Douglas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12837 Simpson Drive, Waldorf, Maryland 20602 Marie Douglas/ Mother 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) May 26, 2011 Suitland, Maryland edar Hill Cemetery 22. Name and Address of Facility Huntt Funeral Home 21. Signal re of Fineral Service Licensee 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ventricular standetill disease or condition resulting in death) Secondary **Medical** Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner day, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 2 🗌 No 1 🗌 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 X No ည 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 X Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 204 22 D 0068540 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25500 295H 's Harp Starl St Mary Lorkout Rd 20650

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** <u>Patricia Ann Daniels</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Plata Medica La If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Year) Days 1 □ M 2 X F 83 1927 Washington, D.C Director 577-34-6656 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Modical Evantion roust or notified at XXYes 2 □ No Maryland | Charles Waldorf 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20602 Funeral 70 Village Street. Apt. 312 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Switchboard Supervisor permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygien Important: If item 27 Is marked other that any Injury or other traumatic event, I'm once. 11th. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ester M. Schwabel Philip P. Quinn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 509 Montgomery St. Apt. 5, Laurel, Maryland 20707 Pamela Wink/ Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 1, 2011 Suitland, MD. Cedar Hill Cemetery 22. Name and Address of Facility Huntt Funeral Home 21. Signatur of Funeral Service Licenses MG/1903035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a co ence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burlal-tran Due to (or as a consequence of): attending physician for use as the burla Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month 5 ☐ Other (specify) 1 ☐Yes 2 No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not presulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has builtector, page 2 st autopsy performed: 1 ☐ Yes 2 ☐ No 1 □Yes 2 Do director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

24 hours after death.

Funeral Director: After the letely filled in by the funeral To the Hospi within 24 hou To the Funel completely fill

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

MAY 31

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Bertha Nelly Arce De Garcia May 23, 2011 /Medical 6:45 P. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7000 Cashell Manor Court Derwood Montgomery 8. Date of Birth (Month, Day, Year)
Nov. 24, 1 If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex . Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 M 2 K F Director 1924 Peru 217-35-6683 86 Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show notified 1 ☐Yes 2X No Director Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or edical Examiner must be 20855 7000 Cashell Manor Court death Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Ite ury or other traumatic event, the Medical Examines 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify. Completed by Specify: 3 X Widowed 4 ☐ Divorced Year or Dates Peruvian White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bolanos Alfredo Ernestina 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelly E. March/Daughter 7000 Cashell Manor Court, Derwood, Maryland 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 MCremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 5/24/2011 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Suprature of Funeral Service License 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer 3 Months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or irjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours, efter death.

To the Funeral Director Atter this certificate has been signed by the attending physiciarrand completely illied in by the funeral director, page 2 should be detached for use as the burdat than standing the page 2 should be detached for use as the burdat transit. Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 2K No 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1□ Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🛭 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated tle of certifier 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 242887

State Registrar

DHMH 17 Rev 1/2001

1396 Piccard Drive, Rockville, Maryland 20850

30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

Leon C. Hwang, M.D.,

MAY 25 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 5 Day 24 2011 Physician/ **fQ:**23 A ^M Donaway Calvin James Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Worcester Berlin Atlantic General Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) Min. Country) Maryland 1 🛛 M 2 🗆 F 61 Yrs. Director 216-56-0448 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 ☐ Yes 2 X No Frankford Sussex DE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 19945 USA 29748 Lazy Lagoon Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Black, White, etc. þ 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes If Yes, Give 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Company Truck Driver 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Littleton Alice Mae Donaway Norman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sł Department of Health a Important: If item 27 is any Injury or other tra P.O. Box 673, Willards, Maryland 21874 Alice Donaway - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-26-2011 Delmar, Delaware Crematory of Delmarva 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Fundral Service Lice 705 E. Main Street, Salisbury, Maryland 21804 23a. rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical 216-56-Box 68760 IF FEMALE: 23c, If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No 9 Unknown certificate has been signed by the certificate has been signed by the detact inector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Tes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death

1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29105 ucceleston MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 103 th. Day, Year) NAY 26 2011 32. Fegistrar's Signature State

Registrar

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical A M 2011 Dorothy 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 231 Canal Park Drive, Apt. 201 <u>Salisbury</u> Wicomico If Under 1 Year If Under 24 Hrs Months Days Hours Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔀 F Months (Month, Day, Year Country Director 577-50-6106 10-30-1917 Canada Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Salisbury Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 231 Canal Park Drive, Canada Apt. 201 21804 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Public Relations Georgetown University injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bruce Felice Frances permit. Page 1 and 2 should be Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 231 Canal Park Drive, Apt. 201, Salisbury, MD 21804 Augustine Dowds - Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1

Burial 2

Cremation 3

Removal from State
4

Donation 5

Other (Specify) Parsons Cemetery 5-27-2011 Salisbury, Maryland 21. Signature of Fungral Service Licenses 22. Name and Address of Facility Bounds Funeral Home any 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of cause on each line. Onset and Death Immediate Cause (Final Physician/ HYPERTENSION disease or condition Medical resulting in death) Due to (or as a consequence of Examiner OLON CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death ed by the detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown KHEUMATOID ARTHRITIS 1 🗌 Yes been signature 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has page 2 s autopsy performe 1 ☐ Yes 2 ☑ No this certificate Yes 2 No 25. Was case referred to medical examiner?
1 2 Yes 2 1 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Prnysi within 24 hours after death.

To the Funeral Director: After this of —completed filled in by the funeral dir 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number M.D. 050929 5 23-30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAY 25 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 21, 2011 0030 Dorothy M. Ebaugh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Lutheran Village Health Care Westminster Carroll 8. Date of Birth
(Month Day, Year)
Dec 25, 1921 Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕱 F Hours Director 217-18-7627 89 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Westminster Carroll 1 XYes 2 No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21158 Funeral 300 St. Luke Circle death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married \$ 1 Yes If Yes, Give 2 X No Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: "natural", Specify. Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ıld be file Mental ⊦ 2 should be filk h and Mental I 7 is marked o Roy Alexander Shipley Ethel Mae Jenkins other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
148 Flintville Rd., Delta, PA 17314 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trans Gay Blizzard - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/4/2011 Kriders Cemetery Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Furieral Service Licen 22. Name and Address of Facil Pritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Falling Physician/ disease or condition Medical resulting in death) Due to (or as a conseque of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying equentially list conditions, Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events and-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death signed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has page 2 autopsy performed' this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 1 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🖪 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director, completed filled in by the 1 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinate On the best of avamination and/or investigation in my policy, death accurred at the time, date and place, and due to the page. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 🗔 29c. License numbe 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) May 23 MIL 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 91140 291 Stone B120 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State MAY 24 Registrar

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036 Physicia Medio Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

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Ith an 27 is trau		Timothy T. Edwards / Son 17 Pontiac Way, Gaithersburg, MD 20878 Oa. Method of Disposition (Name of Date 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town,											o Code)				
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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu			1011			and Addres			/2011				imore Ave	nue	
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To Con		29b. Signature and t	title of certifier	1-0				9c. License					_		, Day, Year)		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mark Samuel FREEDMAN May 22, Physician/ 5:32 P M 2011 Medical 4b. City, Town, or Location of Death Potomac 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 9216 Harrington Drive Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Aug. 23 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 - F 67 Months Days Hours 577-58-7549 1943 Washington, DC **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Potomac Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 with 1 9216 Harrington Drive United States Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. ō ş 1 Never Married 2 X Married ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Specify: "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. S. Freedman & Sons Elementary/Seconday (0-12) College (1-4 or 5+) Paper Company <u>Executive</u> event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Alex Freedman Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Miriam Grossberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C 19a. Informant's Name/Relationship (Type, Print) 9216 Harrington Drive, Potomac, MD Eileen Freedman, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Judean Memorial Gardens 05/24/11 Olney, MD 21. Signal of Fun tral Service License Torchinsky Hebrew Funeral Home , NW, Washington, DC Carroll-20012 254 St 23a. Part 1. East the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 2 Years Immediate Cause (Final Physician/ Glioblastoma Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or impury that initiated page 1). Examine Due to (or as a consequence of): attending physician and I for use as the burint-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown signed by the ad be detached detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 X N has Hospital or Attending Physician: The L 24 hours after death. Funeral Director: After this certificate h 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 X Natural injury 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🛴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) May 23, 2011 D 36797 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alan R. Sheff, M.D., 10215 Fernwood Road, Suite 50, Bethesda, MD 20817 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

MAY 25 2011

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25рм Month Physician/ Marian Virginia Gross Tar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctors Community Hospital Lanham If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. Swanton, 1928 Director 212-24-2316 83 May Usual Residence of Decedent or 28a-f show notified at flied within 72 hours after death with the Maryland al Hygiene. 1 other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Prince George's Berwyn Heights MD 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or must be n Funeral 8611 Cunningham Drive 20740 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Prince George's life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the County School System Teacher Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hw. Important; If item 27 is mark any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dora V. Steiding William Henry Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14709 Chisholm Landing Way, North Potomac, MD 20878 Nan C. Donnells / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, Fort Lincoln Cemetery 6/3/2011 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility 4739 Baltimore Avenue Signature of Funeral Service Licensee Bo Hyattsville, MD 20781 Gasch's Funeral Home, P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Emphysema 20 days disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or imjury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IE EEMALE 23c. If yes, outcome of pregnancy
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1 Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 PInpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending after death.

Director: Aff 1 Tes 2 🗌 No Investigation Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D52815 29 2011 El anoer

State Registrar 12700 Goodloes Promise Drive, Bowie, MD 20720

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

Alexander,

31. Date filed (Month, Day, Year)

MAY 3 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar amend 8 per f.h g918 8/511 Reprising the amend 8 per f.h g918 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2117 Physician/ Month 2011 ASIEL GALLAYE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville Social Security Number None 6. Sex 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) **Funeral** Hours Months Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
 Bart; If item 27 is marked of other than "natural", or items 23a or 28a-f sho lary or other traumatic event, the Medical Examiner must be notified at lury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Prince George's New Carrollton 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 85th Ave., 5334 20784 #D2 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 Married Completed by Yes Baltimore, Maryland 21215-0036 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black 3 🗆 Widowed 4 🗆 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Youssouf Gallaye Jeroma Denton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeroma Gallaye / Mother 5334 85th Ave. #D2 New Carrollton, Md 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important; If ite any injury or otl 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Ft. Lincoln Cemetery 6/1/2011 Brentwood, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Licensee 22. Name and Address of Facility Fort Lincoln Funeral Ketan 3401 Bladensburg Rd. Brentwood, Md 20722 nancis Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition NECROTIZING ENTEROCOLITIS WITH Medical resulting in death) Due to (or as a consequence of) Examiner SEPTIC SHOCK Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed RENAL FAILURE the attending physician and hed for use as the burial-tran Due to (or as a consequence of resulting in death) Last Physician/Medical HYPOTENSION Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Dav Year 2 No 1 Yes 2 L 9 Unknown Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 힏 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending Accident Suicide 1 Yes 2 No neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined within 24 hours a To the Funeral C Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the bast of my hipwings, deeth commodet the time, detelered place, and the to the course(s) and their as state 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 051310 MAY 26 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MISBAH QURESHI mi 9901 MEDICAL CENTER DRIVE ROCKVILLE MARY LAND 31. Date filed (Month, D 32. Regionar's Signature State

DHMH 17 Rev 7/2009

Registrar

MAY S 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Estelle M. Geesling May 2011 7:40A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick

Hodar 1 Year | If Under 24 Hrs. 3021 Basford Rd Frederick Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔼 F Months Days Hours 09/28/1924 Director 578-26-5943 Yrs 86 MD Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🛂 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21703 3021 Basford Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: if item 27 is marked Attack. 1 Never Married 2 Married þ 1 ☐ Yes 2 No 3 ▲Widowed 4 □ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Assistant medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Madison Kennedy Virgie Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3021 Basford Rd., Frederick, MD 21703 Rachel Summers/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 05/24/2011 Frederick, MD 01ivet Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ OBSMichie disease or condition resulting in death) honic Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Examiner Due to (or as a consequence cry. Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 No Month Pregnant at time of death signed by the a g Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 \(\text{D} \) No 24a. Was an has autopsy performed? Yes 2 No certificate in 24 hours after death.

The Funeral Director, After this certifical pleted filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) Meen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Md 217/6 610 MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 25

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JUNE PM 6 JOYCE ELAINE GREEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔽 F 65 Year 946 Mary Land 219-44-2681 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Jefferson Maryland Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 21755 Citizen of What Country? Funeral 3860 Shadywood Drive, Unit 2A · death \ 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. ğ 1 Never Married 2 Married Maryland 21215-0036 "natural", If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White Completed 3X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) uth and Mental Hygiene.
27 is marked other than "I r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Housing Corp. Carpenter 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Margaret Jane Barrett permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic once. Roger Joy, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zip Code) 3810 Roundtree Road, Jefferson, MD 21755 Mrs. Malissa A. O'Hara, daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
St. Paul's Cemetery 1 X Burial 2 \square Cremation 3 \square Removal from State June 9, 2011 Point of Rocks, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fundal Service Line Reemey and Bastord PA Funeral Home 106 East Church St., Frederick, MD 21701 M00255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final recurrent breast cance Physician/ tastatre disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of, cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician; The law requires that the death certificate be executed and tran that initiated events Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Npatient 2 ER/Outpatient 3 DOA 1 Yes မ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: After t 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: Aff
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MOD 35106 M

State Registrar

Hee Nam 400 Myuna W 32. Registrar's Signature

30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print)

7+h St

Frederick, md 21701

State of Maryland / Department of Health and Mental Hygiene For State Registrar #17,#18 per FH 06/06/20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:30 P M John R. Harris May 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Prince George's Cheverly Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Age (In yrs. last birthday) **Funeral** Country) DC Months Hours Min. Mar 2 69 Yrs 579-54-8053 Director Usual Residence of Decedent show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medic | Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Upper Marlboro 1 X Yes 2 No MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9415 Castle Drive 20772 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married þ 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Baker Private 12th Be 18. Mother's Name (First, Middle Maiden Sumame) Anne Lauri R^{USSEL} Unknown 17. Father's Name (First, Middle, Last) ဂ္ John E. Harris - Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9415 Castle Drive, Upper Marlboro, MD 20772 Yvonne M. Harris/ Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State 06/06/2011 Riverdale, MD 4 Donation 5 Other (Specify) Riverdale Crematory 22. Name and Address of Facility J.B. Jenkins Funeral Home Signature of Funeral Service Licensee 7474 Landover Road, Landover, MD 20785 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or hear railure. List only one cause on each line? Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as Examine attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Physician/Medical 68760 23b. Was decedent pregnant 23d Date of delivery Box (Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? s been signed to should be deta à Records, 1 Yes 2 🕽 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performa 1 ☐ Yes 2 ☐ No in 24 hours after death.

he Funeral Director: After this certific pleted filled in by the funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner?

1 Yes 2 X Other: မ Inpatient ER/Outpatient 3 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural Pending Division 1 Yes 2 No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and minimal as datased.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) the 29b. Signature and title of certifier 2 of person who completed cause of death (Item 23a) (Type, Print) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Hummel May 22^{Day} Physician/ Catherine 2011 12:35A. M Medical 4a, Facility Name (if not institution, give street and number) 3148 Gracefield Road, #604 4b, City, Town, or Location of Death Silver Spring Ac. County of Death Prince George's Examiner 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🂢 F Days Min OCT. 3 1932 Hours 314-36-5749 78 Kentucky Yrs **Director** Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director Maryland | Prince George's 1 🗆 Yes 2 💆 No Silver Spring 10f. Zip Code 20904 ō 10e. Street and Number 10g. Citizen of What Country?
United States ral", or items 23a o Examiner must be Funeral 3148 Gracefield Road, #604 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: "natural" 3 Widowed 4 X Divorced Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant. If item 27 is marked other than "naturury or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Law Firm Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johnson ၀ Hummel Gladys Arnim 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 236 36th Avenue, #B San Mateo, CA 94403 19a. Informant's Name/Relationship (Type, Print) Karen Marie Schacht -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ridgebury Cemetery 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o
once. 1 🔀 Burial 2 🗀 Cremation 3 🔀 Removal from State 5/28/2011 Ridgefield, Connecticut 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23. Name and Address of Facility Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Colon Cancer Ph. sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and perpeted filled in by the funeral director, page 2 should be detached for use as the burialtransit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No 3 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2A No 2 🔀 No Yes 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 2 X No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury 5 Pending М Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ertifier 29c. License number 29d. Date signed (Month. Day. Year) D64983 May 23, 2011

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kashif Firozvi, M.D. 2101 Medical Park Drive, #200 Silver Spring, Maryland 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 861 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Eleanor H. Holzberger May 22 2011 3:05 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb. 20, 1 □ M 2 🖺 F Months Days Hours Min. 579-16-1606 Year) 1921 Washington, DC Director 90 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Maryland | Montgomery Kensington 1 No Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20895 United States 3618 Littledale Road, #309 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 K Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. d other than " Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ၉ Frederick H. Wheeler Carrie Grace Eshelman traumatic 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25114 Vista Ridge Rd., Gaithersburg, MD 20882 Paul E. Holzberger (Son) other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 May 25, Gate of Heaven Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 2011 22. Name and Address of Facility DeVol Funeral Home, (M00689)10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Cardiac Arrythmia Onset and Death Cardiac Arrythmia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Pregnant at time of death Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗌 No 3 🗎 Probably 4 🏝 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed? Yes 2 X No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🔀 No မှ 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 2300 22-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Said A. Daee, M.D.,
31. Date filed (Month, Day, Year)

MAY 25 2011

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2. Registrar's Signature

7525 Greenway Center Dr., Greenbelt, Maryland 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:40 M May 21, 2011 Year Physician/ Harter Carolyn Ruth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 18602 Meadowland Terrace Olney 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birtholace (State or Foreign ocial Security Number 149-26-8650 **Funeral** Hours Min 1 M 2 X PA 91/2/87/1931 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director State College PA Centre 1 🗆 Yes 2 🎽 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1349 Penrose Circle 16801 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14, Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Specify 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Public Schools Elementary Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Violet Ruth unknown မ James A.Hinds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 18602 Meadowland Terrace Olney, Md 20832 Ian Deveau/Son-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State Pennsylvania Pennsylvania Furnace, Graysville Cem. 5/27/2011 4 🗌 Donation, 5 🔲 Other (Specify) Aneral Service L PHILIP dd P. RINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ End stage renal disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HTN Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last as the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ☐ Live Birth 2 ☐ Felai Go...
☐ Pregnant at time of death Month Year Day 5 Other (specify) g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 🔼 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy page performed 1 Yes 2 No s after death.

I Director: After this certifical and in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) son-in-law ecity) home Hospital: Other: 2 XNo 4 Nursing Home 5 Residence 6 Other (Spec မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 \square Pending work 1 Yes 2 No Accident Investigation 6 Could not be Suicide within 24 hours after de

To the Funeral Directo

completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

G.Coleman M.D.

6001 Muncaster Mill Road Rockville, Md.

f person who completed cause of death (Item 23a) (Type, Print)

30. Name and address

D37142

May 23,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 17. Thelma Johnson 2011 0225 М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2 📭 Days Hours Min. une 2, 1937 239-56-4852 Director 73 June Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 947 Wampler Lane 21158 death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Š 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X** No 72 hours after 1 ☐ Yes 2 X No Specify: "natural", Specify: Completed 3XXWidowed 4 ☐ Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene. 77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 Public School System Custodian any injury or other traumatic event, once Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Lloyd Parker Nellie Cuthbertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Brenda Roper, daughter 947 Wampler Lane, Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gard. 5/20/2011 Finksburg, MD on ture In uneral Service Licensee 22. Name and Address of Facili Pritts Funeral Home & Chapel, PA X 412 Washington Rd. Westminster, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final CHRONIC OBSTRUCING PULMONARY DISCAFE Physician/ disease or condition LO GEAR Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of: sician and burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š or Attending Physician: The law requires Completed 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' Yes 2 certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 WNo Deve Heder ည 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28c. Injury at 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral Hospital To the MJL

Medical

29a. Certifier

only one)

Maryland 21215-0036

Baltimore,

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

reand address of person who completed cause of death (Item 23a) (Type, Print) II ms

S

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

231660

STONER AVENU

29d. Date signed (Month, Day, Year)

WESMINSTER MAYLA

21157

29c. License number

Tex

Schun

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death ^D2011 Physician/ May 18, 3:00 a Rose Therese Kretzschmar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Examiner Westminster Carroll Hospice Dove House Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. **Funeral** . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Oct 3, 1929 1 - M 2 X F Months Hours Massachusetts 020-22-7750 81 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Finksburg Maryland Carroll 1 Yes 2 No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21048 2893 Constellation Way USA items be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 1 Never Married 2 Married ō ρ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. white "natural", Specify 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of 2 permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Mortimer A. O'Sullivan Rose Marie Terry other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Kretzschmar, husband 2893 Constellation Way, Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State All Saints Cemetery 5/23/2011 Reisterstown, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis St, Westminster, MD 21157 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ C disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 burs after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur completed filled in by the funeral director, page 2 should be detached for use as the bur and the state of the page 2 should be detached for use as the burn. P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 XOth Hospice 2 100 ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Mann Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu 29d. Date signed (Month, Day, Year, WJL 12 (Item 23a) (Type, Print) 30. Name a

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

WESTMINSTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2011 Year May Czeslawa Kierpiec 28, 2:46 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Columbia Howard 5. Social Security Number 6. Sex **Funeral** Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 1 🗆 M 💥 🗆 F Months Days Hours July 3, 1922 Director 478-40-9577 88 Poland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6336 Cedar Lane Rm 322A 21044-3994 items United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc ō 1 Never Married 2 Married ould be filed within remained and Mental Hygiene. is marked other than "natural", o Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 10College (1-4 or 5+) Janitor Janitorial other traumatic event, Be 17. Father's Name (First, Middle, Last) should be file and Mental F is marked of 18. Mother's Name (First, Middle, Maiden Surname) ပ Antoni Sobierai Janina Maczaszczyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Peter Kierpiec/son 5925 Gentle Call Clarksville, Maryland 21029 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1. Department of I Important; If it any injury or of ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory 5/31/2011 Hanover, Maryland
22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Licenses uanta R Thomas M00957 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition PNEUMONIA DAYS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or impury that initiated events Examiner Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 DNo
9 Unknown 4 Pregnant at time of death 9 Unknown Month Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC OBSTRUCTIVE PULMONARY Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy 1 Tyes 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 1 ☐ Yes 2 X No ပ Other: 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 124 hours after death e Funeral Director: A lleted filled in by the fi Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: Off the Dasis of Gould Miles Miles and Miles Practioner: To the best of my knowledge within 2 To the I 29b. Signature and title of certifie D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 36 CEDAR LANE COLUMBIA, MD 21044 DANIEUE DOBERMAN, MO 63

DHMH 17 Rev 7/2009

State

Registrar

recent.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State	of Maryla					d Mental	Hygie	ne			
			1 - State Registrar Certificate of Death Reg.									No.2	11	18551	
Phy	/sicia	n/	Decedent's Name (First, Middle					2. Date of Month	1	Day	Year	3. Time of Death			
	/ledic		CARLTON THEO					May	· · · · · · · · · · · · · · · · · · ·			6:21 A M			
Ex	4a. Facility Name (if not institution, give street and number) FREDERICK MEMORIAL HOSPITAL							own, or L DERI	ocation of De	eath	4c. County of Death FREDERIC			rk.	
Fun	eral		5. Social Security Number	last birthday)	If Under 1		If Under 24 H		of Birth			place (State or Foreign			
	ctor		216-60-9137	1 🖾 M 2 🗆 F	42	Yrs.	Months	Days	Hours M	June	h,Dav,Yea	1968	Cour Ma	ryland	
p Ao	Į,	L	Usual Residence of Decedent 10a. State 10b. County		100.0	ity, Town or Loc	vation							40.1 1-11-11-11-11-11-11-11-11-11-11-11-11-	
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eath tem s	er m	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?				. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-								
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5-0050 hours after "natural", o	alEx	Completed	3 Widowed 4 Divorced		1 ☐ Yes 2 🖾 No Specify:					Specify	Wh	ite			
72 h	Medic	ם	(Specify only highe	T		(Give I	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b. Kind of Business Industry			
LLID-UU30 Within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho	the		Elementary/Seconday (0-12) 12	College	(1-4 or 5+)		Manag	,			Auto Parts				
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Naryland should be filed and Mental Hy 7 is marked ott	atic e	۵	Carlton Lamar King Susan Jean Hammond												
Nical 2 shou Ith and 27 is m	raum		19a. Informant's Name/Relationsh							Rural Route No				,	
and 2 Healti	Important; If item 27 is marked any injury or other traumatic ev once,		James Patrick M 20a. Method of Disposition	cHenry/Si					ino Xi:						
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Dep Deb	any		Ball 9	00/1/1	M		auffe 21 Op	r Fu	neral	Homes Pike,	P. A. Frede	rick.	Mary:	land 21702	
			23a. Part 1. Enter the disease, or	complications that	caused the dea								Ī	Approximate	
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Med Exam	dical		resulting in death)									5-71			
		. e	Sequentially list conditions,	b. —	b. Due to (or as a con equence of):									days	
pa	physician and the burial-transit	Ë	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to	D - 1	duence of):	∵s							5-7 days 7 days	
execut n and	al-trar	Exa	that initiated events resulting in death) Last	quence of):											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	e pri	dical Examiner		d											
oo/o ertificat ding ph	as th	9 1	IF FEMALE:												
eath certificate attending p	or use	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Liv	utcome of pregr e Birth 2 🗌 Fe	tal death 3							te of deliv	*	
e death of the atter	hed fo	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pre 9 ☐ Un	gnant at time of known	fdeath 5∟	Other (spe	cify)			_	Mo	onth	Day Year	
hat the	detac	됩	Part II. Other significant condition	ns contributing to	death but not re	esulting in the u	nderlying ca	use giver	n in Part I.	23e.	Did tobace	co use cont	ribute to tl	he cause of death?	
lires t	ld be	d by								_	1 🗌 Yes	2 🗌 No	3 🗆 Pro	bably 4 Unknown	
e law requires has been sig	shou	Completed								24a.	Was an	, , , ,			
he far	age	E O									autopsy performed	12	prior to co death? 1 □ Yes		
ian: T	ctor, p	Bec	25. Was case referred to medical examiner?					26. Plac	e of Death (C	1 Check only one)	Yes 2	INO	i 🗀 tes	2 🗆 110	
hysic his ce	l dire	2	1 Yes 2 No		Inpatient 2		t 3 🗆 DOA	Other:	4 🗆 Nursin	g Home 5 🗆	Residence	e 6 🗆 Oth	er (Specify	2	
ling Pl	unera	ate:	27. Manner of Death 1 Natural 5 Pendin		e of injury nth, Day, Year)	28b. Time of injury		c. Injury a work?		28d. Desc	ribe how ir	njury occurr	ed		
or Attendir fter death. irector: Aff	/ the /	Certificate	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could	not be	e of Injury - At h	nome form stre	M ot factors		es 2 🗆 No	001.1					
after Direct	d in b		4 ☐ Homicide determ		ding, etc. (Speci		et, lactory,	onice			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
DIVISION OF VICE THE COLUS, F.O. DO To the Hospital or Attending Physician: The law requires that the dewinthin 24 hours after death. To the Funeral Director: After this certificate has been signed by the answer of the control of	d fille	Medical	29a. Certifier 1 Certifying	Physician: To the	best of my know	wledge, death o	ccured at th	ne time, d	iate and plac	e, and due to the	ne cause(s) and mann	er as state	ed.	
the Horin 24 the Fu	nplete	Med	only one) 3 ☐ Certifying	Nurse Practioner	asis of examinations: To the best of r	on and/or invest ny knowledge, c	igation, in m	y opinion, ed at the t	, death occurr time, date and	ed at the time, of place, and due	date and pl to the cau	ace, and du se(s) and m	e to the ca anner as st	use(s) and manner stated, tated.	
To T	000		29b. Signature and title of certifier				29c. I	License n	number		1 /	Date signe		*	
D65378										1/4	ay Z	,20	//		
5			30. Name and address of person v	who completed car		m 23a) (Type, P		Wes	t 7+h	Street		V		land 21701	
<u> </u>	Stat	e	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	ature .	- 400	WES	C / LII	DITEEL	, rred	GLICK	,riar)	y 1 a 11 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
Re	gistra		MAY 2	5 2011	Genera	B. A	arks								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) ,2011 Koehler Physician/ 0. 6:00p M Мау 19 Joseph Medical 4b. City, Town, or Location of Death Silver Spring 4a. Facility Name (if not institution, give street and number) 4c. County of Death Montgomery **Examiner** Fox Chase Nursing Center 7. Age (In yrs. last birthday) 72 Yrs. 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 5. Social Security Number **Funeral** Wash., D.C. 1 🔀 M 2 🗆 F Months 1 11/12/04 1938 579-50-8207 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director 1 Yes 2X No Silver Spring Md Montgomery 10f. Zip Code 10q. Citizen of What Country? 10e. Street and Number Funeral 20910 2015 East West Highway USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married Completed by White Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department Store Security Guard 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lorraine Koehler ည unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1511 E Street S.E. Washington, D.C. 20003 Evelyn Fleming/Guardian 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place) ☐ Burial 2 【★Cremation 3 ☐ Removal from State 5/21/2011 Beltsville, Md. Chesapeake Crem. 4 Donation 5 Other (Specify) PHILIPADERTNALDI FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licensee/ any 9241 Columbia Blvd.Silver Spring.Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Cancer of tongue Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlyin Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last the attending physician and thed for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ diabetes mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed within 24 hours after death.

To the Funeral Director. After this certificate has been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 🗌 Yes 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital Other: မ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: injury work? 1 🗌 Yes 2 🗆 No 1 X Natural 5 Pending M Investigation 6 Could not be 2 Accident 3
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1.Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature d title of certifier 29c. License number May 20,2011 D28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15245 Shady Grove Rd. Suite 130 Rockville, Md 20850 Passi M.D31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

MAY 25 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Month Physician/ Elizabeth Frances Keegan a^{M} 1:20 May Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Arden Courts Kensington If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) D.C. 1 ☐ M 2 🖾 Days Hours Min Oct. 30, 1924 Months 86 Director 578-22-0227 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at with the Maryland Director notified 1 Yes 2 No MD Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? 6 10e. Street and Number be r Funeral items 23a 4301 Knowles Avenue 20895 USA other traumatic event, the Medical Examiner must death 12. Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 0 þ 1 Never Married 2 Married 2 🔯 No Maryland 21215-0036 within 72 hours after ☐ Yes If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify:White "natural" 3∑ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elizabeth Victoria Knott Thomas Joseph Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Flower Valley Drive, Rockville, MD 20853 Kevin C. Keegan/Son 4716 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cemetery Silver Spring, MD 22. Name and Address of Facility. Francis J. Collins 00 University Blvd. 21. Signature of Funeral Home . W., Silver Home Inc. ver Spring MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Cardiomyopathy Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Alzheimer's Dementia Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a nonsequence of Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Day 5 Other (specify) Pregnant at time of death signed by the a d be detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b cate has page 2 s autopsy performed? Yes 2 No death? 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🖾 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 🖾 Natural injury 5 Pending 2 Accident Investigation completed filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 [3 [(Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

29b. Signature and title of certifier

30. Name and address of person w

31. Date filed (Month, Day, Year)

Alpana Goswami, MD

NAY 25 2011

completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

-27660

11125 Rockville Pike, #110, Rockville, MD 20852

29d. Date signed (Month, Day, Year)

11

24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10a-c,e,f,perf#2perff#2perff#S,7/21/2011,ws

State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Maty 22 Pa 2011 Year 5:52p M Physician/ Michael Kostishak Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3013 Winifred Drive Burtonsville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ▲M 2 □ F Days Hours Mir Months 181-26-7653 1070471931 79 Director Usual Residence of Decedent or 28a-f show notified at a. State **Opida** ^{10c.} De Fray Beach Burtonsvil 10d. Inside City Limits filed within 72 hours after death with the Maryland Pafm Beach Director Montgomery 1 Yes 2 No ō 10f. Zip Code 33484 10g. Citizen of What Country? 10e F6886 AmbIsle of Palms Drive ms 23a or must be Funeral Winifred Drive 20866 USA items 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No 1953
If Yes, Give 1955 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc. or, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify. Specify 3 XWidowed 4 ☐ Divorced 1955 Completed Year or Dates Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene.

(m) Portant: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Peter Kostishak Marie Torick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6001019a. Informant's Name/Relationship (Type, Print) Denise Hook/Daughter 44 Old Barrington Rd.Lake Barrington, IL. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Indian to bisposition (Name of competery, crematory or other place, Indiantown Gap National Cem 1 🗷 Burial 2 □ Cremation 3 🔀 Removal from State Annville, Pa. 5/27/2011 4 Donation 5 Other (Specify) PHILIDEL ADES REMALDI FUNERAL SERVICE P.A. Funeral Service Lice 21. Signatur 9241 Columbia Blvd.Silver Spring,Md20910 Men 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metastatic Prostate Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No s been signed by the s should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an as autopsy performed? Yes 2 No page death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Žná Hospital 2 🔀 No Other: 6 X Other (Spec 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 Yes 4 Nursing Home 5 Residence home After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 XNatural injury 5 Pending within 24 hours after death.
To the Funeral Director: A Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tile of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35579 20/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J.Miller, M.D. 8218 Wisconsin Ave #305 Bethesda, Md 20814

State

Registrar

31. Date filed (Month, Day, Year)

MAY 25 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 23 2011 07:00A May Lynch William Α. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick 6885 Arbor Court Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 156 M 2□ F 92 Yrs. 22 1919 Maryland 217-05-4612 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be rediffied at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 No Frederick MD Frederick Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number United States 21703 6885 Arbor Court by Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Yes 2 No f Yes, Give 1 Never Married 2 Married White WWII 1 ☐ Yes 2 🗷 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Promotional Products Salesman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nettie Allnutt William Τ. Lynch 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6885 Arbor Court, Frederick, Maryland 21703 Louise E. Lynch / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5/26/11 Gaithersburg, MD Forest Oak Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear that ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BLADDER CONCER disease or condition resulting in death) Due to (or as a consequence of): ATRIBL FIBRILITION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit ANZALLIA that initiated events iding physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical CAT IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day atten Month Year jo in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No been signed by the s should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed

Physician /Medical **Examiner**

Baltimore, Maryland 21215-0036

certificate be executed

Division of Vital Records, P.O. Box 68760.

Attanding Physician:

ŏ

this

After

after death Diractor:

within 24 hours a To the Funeral L To the Hospital

filled in by

Medical

Completed Be Certification; To

1 ☐ Yes 2 1 No 26. Place of Death (Check only one)

28d. Describe how injury occurred

Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

2□ No 1 Yes

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

29b. Signature and title of certifier

5 Pending

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) investigation

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only onel

1 Natural

2 Accident

3 Suicide

4 Homicide

Nurse Practitioner

29c. License number PC69310

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Jun Hashe Luda Lex

30. Name and address of posion who completed cause of death (Item 23a) (Type_Print)

+1250 ZRCh, MD 21702 1564 Opossenten Kile. LINDAC . M UEHL CEUP

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

8 + 1VA State Registrar

31. Date filed (Month, Day, Year) MAY 25 2011

32. Registrar's Signature barke

DHMH 17 Rev 1/2001

ORIGINAL

29d. Date signed (Month, Day, Year)

5 23 11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mraty 20, Day 2011 Year 935 PM M Doris Levy Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1799 East Jefferson Street #218 Rockville Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Funeral 579-40-1916 1 □ M 2 👿 F 88 Months Days Hours Min. 0790871922 Washington, DC **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Rockville 10d. Inside City Limits 72 hours after death with the Maryland Director Montgomery 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or Funeral 1799 East Jefferson Street #218 United States 20852 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Black, White, etc. White Armed Force 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes Give Specify. 3 X Widowed 4 Divorced Completed Year or Dates marked other than "natu matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Walter Reed Medical Elementary/Seconday (0-12) College (1-4 or 5+ Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andrew Peterman Lottie Cohen 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherri Casey - Daughter 13914 Baldwin MillRoad Baldwin MD 21013 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State Judean Memorial Grdns 05/22/2011 Olney, MD 4 Donation 5 Other (Specify) 21. Signature of Fancial Serial 22. Name and Address of Facility
Edward Sagel Funeral
Rockville Pike nsee M01163 Rirection isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1. Enter the Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph, sician/ Pulmonary Fibrosis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, Examine Due to or as a consequence of cause Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed P that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No for Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 W Unknown Pulmonary Hypertension peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2; this certificate has autopsy death? performed? 1 ☐ Yes 2 ☐ No Yes 2 V No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 🔀 Residence 6 🗌 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi

completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending work X Natural 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda Anne Benson MD 6121 Montrose Road Rockville MD 20582 31. Date filed (Month, Day, Year) MAY 25 2011 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:15 P.M 22, 2011 May Chin Lee Shu /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Potomac Valley Nursing Center Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 89 China 1, 1921 Director 217-72-1244 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 Funeral 5716 Magic Mountain Drive United States Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 X No Specify. Specify: þ 3X Widowed 4 □ Divorced Asian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Home Homemaker other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 Is marked ot traumatic ever Tsong Sian 2 San Kuo Tsong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. 5716 Magic Mountain Drive, Rockville, Maryland 20852 Meng K. Lee/ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 5/26/2011 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Metropolitan Crem. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each-line. Immediate Cause (Final disease or condition resulting in death) or dupilities **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Restentis Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director; After this certificate has been signed by the attending physician and as the buria transit Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 🛛 Naturai 1 □ Yes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by determined 4 ☐ Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29c. Licenşe number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Registrar

Marichu Theresa A. Matas, M.D., 9901 Medical Center Drive, Rockville, MD. 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NAY 25 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 21, Day 2011 Year Physician/ 10:08 ам Bella Bessy Machata Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Manchester Long View Nursing Home If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Czech Republic Months Days Hours Min. Jan 5, ^YT921 90 **Director** 522-40-1664 Usual Residence of Decedent 10b. County 10d. Inside City Limits ms 23a or 28a-f shomust be notified at 10a. State within 72 hours after death with the Maryland 10c. City. Town or Location Director Taneytown 1 Yes 2 X No Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21787 3267 Rolari Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Examiner Black, White, etc. 0 1 ☐ Yes 2 🗷 No If Yes, Give 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify: white "natural", Specify: Completed 3. Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Airlines In Flight Kitchen Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Barbora Kulikova Vaclav Kulik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3267 Rolari Drive, Taneytown, MD 21787 Bella Hartle, daughter Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5/31/2011 4 Donation 5 Other (Specify) Denver, CO Mt Olivet Cemetery 22. Name and Address of Facility Signature of Funeral Service Licensee Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 🔐 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) DNGESTIVE Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown P.O. Part In Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown PULMONARY DASTRUCTIVE 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 22 autopsy performed? Yes 2 N 1 Yes 3 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury Natural 5 Pending 2 No 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier WIL 28575 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 ASNEEM SmiTH 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Medical Month Marjorie Lee Maynard 1:30 P M May 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Hospital Center 9. Birthplace (State or Foreign Country)
Baltimore, MD 8. Date of Birth (Month, Day, Year VOV 25 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** Days Hours Months Director 918 <u> 217-07-0251</u> Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Yes 2 No Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21157 U.S.A. Funeral 97 W. Green St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) Annie Maude Horchler 17. Father's Name (First, Middle, Last) Herbert Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Schmidt - Daughter 97 W. Green St., Westminster, MD 21157 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State 5/25/2011 St. John Cemetery Ellicott City, MD 4 Donation 5 Other (Spe 22. Name and Address of FacilitPritts Funeral Home & Chapel, PA 21. Signature of Funeral Service 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 1 Yes 2 No Month Year Day Other (specify) Pregnant at time of death To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death.

Director: After this certificate has autopsy perform death? 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29c. License number 29d. Date signed (Month. Day, Year) WJL 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 349 Kahena lal Mah 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05 2011 Ada Nelle Martin 0800 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll 85 W. Green St. Westminster 8. Date of Birth (Month, Day, August 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2🔀 F Months Days Hours Min. Country) **Director** 213-24-2725 89 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 □ No Carroll MD Westminster 10e. Street and Number 10f Zip Code 0 10g. Citizen of What Country? Funeral and Mental Hygiene. is marked other than "natural", or items 23a 21157 USA 85 W. Green St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) LPN Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allie Mae O'Bryant William Daniel Todd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is 85 W. Green St., Westminster, MD 21157 Judi Johnson, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any injury or 1 X Burial 2 Cremation 3 Removal from State Saters Baptist Church 05/21/2011 Lutherville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Acense 22. Name and Address of Facility Pritts Funeral Home & Chapel 21157 412 Washington Road, Westminster, MD 23a. Part 1. Enter we disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 5 Other (specify) Month Dav Pregnant at time of death P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsv perform death? 2 📮 No Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending injury work? 5 Pending safter death.

I Director: Aff
in by the fur 2 🗆 No ☐ Accident☐ Suicide Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Direct completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa 29d. Date signed (Month. Day, Year, WSL nd address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mav Day 2011 25 Gabriel Eugene Maravetz 8:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist of Howard County Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
May 19, 1939 Social Security Number Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign **№** м 2 🗆 ғ Min. Hours Director 483-42-9199 72 Iowa Usual Residence of Decedent nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland dartment of Health and Mertal Hygiene. Artment of Health and Mertal Hygiene. ordant: If item 27 is marked other than "natural", or items 23a or 28a-f show injuy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9116 Flamepool Way 21045 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 Never Married 2 X Married Completed by XYes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: 3 Widowed 4 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer US Navv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Clement Maravetz Zbornik Agnes Gertrude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colette E. Maravetz/wife 9116 Flamepool Way Columbia, Maryland 21045 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 6/3/2011 Crownsville, MD re of Funeral Service License 22. Name and Address of Facility larry H. Witzke's Family F.H. Inc M00957 4112 Old Columbia Pike Ellicott City, MD 21043 momas 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 2009 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events Direct: Exists a consequence of executed and -tran resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown ATRIAL FIBRILLATION OBSTRUCTIVE SLEEP APNEA 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Jas this certificate 2 🗌 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 XNo Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? after death. Director: Aft 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 64395 MAY 26,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR LANE COUMBIA, MD 21044 51 DANIEUE DOBEPMAN, MO

State Registrar

1-03883			pe or Print in B						egibl	e.			
rancis Wilbur I	vlorg	an S 1- For State	tate of Maryland			of Health a of Death	and Menta	al Hygiene	D N .	201	18665		
Physici ledical Exam		Registrar 1. Decedent's Name (First, Midd Francis Wil			imouto (2. Date of D Month May 24,	Day	Year	3. Time of Death 1340 hrs		
		4a. Facility Name (if not institution	on, give street and number				n, or Location of		40	c. County of Deat			
Funeral		5 Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birth											
Director	è	577-88-2174 Usual Residence of Decedent	1XM 2 F	50			Days Hours	Min	2/19	Forei	gristrict of ountry Columbia		
Any		10a. State 10b. County						10d. Inside City Limits					
Maryland 28a-f show d at once.	or	Md Prince George's Lanham									1 X Yes 2 No		
the Mary n or 28a- tified at	Director	10e. Street and Number 8415 Hamlin	St., #104			10f. Zip Cod 2070			10g. Cit	izen of What Coo	untry?		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 M	12. Was Decedent	2				? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame White, etc.	rican Indian, Black,		
fter de I", or i		3 Widowed 4 X Di	Vorced If Yes, Give Year	X No	1	Yes 2X	No specify:			Specify: B1	ack		
nours a natura Examir	ed by	15. Decedent's Education (Spe					upation (Give kir life. DO NOT us		16b.	Kind of Business	/Industry		
36 nin 72 l e. than "1 dical E	Completed	Elementary/Secondary (0-12)) College (1-4 or	5+)	_		n Worke			Privat	e		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medisa	Соп	17. Father's Name (First, Middle	e, Last)			·	18.Mother's	Name (First, Middle	Middle, Maiden Surname)				
121 d be fil ental F	Be C	David Leon Mo 19a, Informant's Name/Relation:			40h Mail	an Address (O		bara Colm		1 T C4-4	a Zio Codo		
MD 2 d 2 shoul lth and M n 27 is m	Ľ	Stephanie Mo:		ter	19			er or Rurai Route N 104Lanh					
e, N 1 and 2 Health item 2		20a. Method of Disposition		20b. P		osition (Name o		Date		Location - City o			
Pages nent of note by		1 Burial 2 X Crematio 4 Donation 5 Other S	on 3 Removal from St Specify:	ara	Linco	1n Crem		6/6/11		entwood			
Baltimore, permit. Pages I ar Department of Hee Important: If ite Injury or other tr		21. Signature of Therman rvice	e Licensee			Fort Line							
Physician		20a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Returned Operations											
/Medical Examiner	1 13	failure. List only/one cause Immediate Cause Final disease		theroscle	erotic Car	diovascular	Disease				Between Onset and Death		
ZAGIIIIICI		or condition resulting in death) Due to (or as a consequence of):											
	ner	UNPENDED AMENDED If FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery											
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Box 68760, e death certificate be exe the attending physician and for use as the burial -	/Mec										·		
lox 68 eath certif e attending for use as	ician	2 2.50. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (Specify)								Day Year			
Bo he deat y the at hed for	hys	Part II. Other significant condi	9 Unknown	h hud not so	aulting in the	. underhång og u	eo givon in Dort	23a Dio	Ltobacco	use contribute to	the cause of death?		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Ď	Diabetes Mellitus	contributing to deat	n but not re	sulling in the		se giverrin Fait	" -	_		bably 4 VI Unknown		
Cords law requi	Completed					_			opsy	prior to	utopsy findings available completion of cause of		
tal Recc tian: The lav certificate ha	Com							1 ✔ Yes	formed?	death? 1 ✓ Y	es 2 No		
Vital Rec ysician: The l his certificate director, page	Be	25. Was case referred to medica examiner?	Hospital:	ent 2	ER/Outpatie		Other	heck only one) Nursing Home 5	Reside	ence 6 Othe	er: Scene		
n of V ding Phy After thi funeral d	n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day,)	ıry T	28b. Time o		Injury at Work?	28d. Describ					
ision Attendi er death. rector: ,	atio	The state of the s									I D. A. Nambar Ott		
Divis wital or A urs after oral Dire	Certification:		28e. Place of Ir ermined (Specify)	ijury - At ho	me, farm, str	eet, factory, offi	ce building, etc.	28f. Location or Town		and Number or R	ural Route Number, City		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical C	(Official daily)	Physician: To the best of maminer: On the basis of exa and manner stated.										
F 3 F 3	29b. Signature and title of certifier 29c. License number									Date signed (Mo	onth, Day, Year)		
. 4		30. Name and address of person						D 04655					
		Ling Li, MD Assista 31. Date filed (Month, Day, Year)	ant Medical Examine 32. Registr	120		ore Street, E	saltimore, Mi	D 21223					
Si Regis		MAY 3 1 2011	Denne B	40	Mary.								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland / [lealth and N	fental Hy	giene			
			Registrar			Certific	ate of	Death		Reg. No. 2	011	18566	
	Physicia	an	1. Decedent's Name (First, Middle, I	_ast)					2. Date of Dea	Day	Year	3. Time of Death	
major id	/Medic		Horace James	41- 6	itu. Taura ar	r Location of Death	05	23	2011 inty of Death	11:30 am			
, de	Examin	er	4a. Facility Name (If not institution, g		D 1 1								
	Funeral		St. Thomas More 5. Social Security Number 6.		Renab. e (In yrs. last bir	thday) If Ur	lyatts der 1 Year	If Under 24 Hrs.	8. Date of Birt	h	ince G	place (State or Foreign	
	Director		578-42-0752	1⊠M 2□F	76	Yrs. Mont	hs Days	Hours Min.	(Month, Da 08/16/	y, rear) 1934	North	n Carolina	
	pu »		Usual Residence of Decedent									I0d. Inside City Limits	
	shov	ř	10a. State 10b. County		10c. City, Town						1'	1A Yes 2 No	
	the N	Director	MD Prince 10e. Street and Number	Georges	rly 10f. Zip Code				10a Citizen	of What Cour	ntrv?		
	with 3a or					101.	20785						
	ms 2	Funeral	6445 Forest Ro 11. Marital Status	12. Was Decedent 8	Ever in U.S.	13. Was De		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		SA Race - Americ		
ဖွ	or ite	Fu.	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X N If Yes, Give	No		pecify Cuba	an, Mexican, Puerto Specify:	Rican, etc.)		Black, White,	etc.	
္က	ural",	d by	3 Widowed 4 Divorced	Year or Dates:		1 110	241110	эреспу.			ec <i>ify:</i> B 1 a		
21215-0036	"natı	Completed	15. Decedent's (Specify only highest of	(Give kind of	dent's Usual Occupation kind of work done during most of working 16b. Kind of Business/Industry								
12	withir ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5	+)	Manage		1)		Pot	ail Sa	100	
9	filed Hygi Sther ent, I	Be Co	17. Father's Name (First, Middle, La	st)		Manage	=1	18. Mother's Name	e (First, Middle,			162	
lan	should be filed within 72 hours after death with the Maryland mind Mental Hyglene. In the Hyglene snarked other than "hatural", or items 23a or 28a-f show marked other than "hatural", or items 23a or 28a-f show umatic event, it as the close Examination of the content of the c	To B	James May					Mellare	e Full	er			
Maryland	should have	_	19a. Informant's Name/Relationship	(Type. Print)	19b	. Mailing Addr	ess (Street	and Number or Run			wn, State, Zij	o Code)	
Σ	and 2 ealth n 27 I		Velinda Mays-C	arter		6445 F	orest	Road C	heverly	, MD	20785		
ore	jes t t of H if iter or oth		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3	☐ Removal from State	20b. Place of cemeter	f Disposition (ry, crematory	Name of or other plac	ce)	Date	20c. Location	on - City or To	own, State	
altimore,	: Pag tmen tant: jury		4 □ Donation 5 □ Other (Spec		Ft. Li	ncoln	Cremat	tory 05/26	/2011	Bre	ntwood	, MD	
Bai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its marical Era, its must be a difficult once.		21. Signature of Funeral Service Lic	ensee	JA.	22. Name	and Addre	ss of Facility Ft.	Lincol	ln Fun	eral H	ome, Inc.	
			23a. Párt1. Enter the disease, or co	Juney Ul	the death Day			ensburg Ro			d, MD	20722 Approximate	
		17	shock, owneart failure. List on	ly one cause on each lin	ne.	not enter the i	node or dyn	ig, such as cardiac	or respiratory a	irest,		Interval Between Onset and Death	
- Section	Physician /Medical		disease or condition resulting in death)	a. Sepsis		-1)-							
الممس	Examiner			,	a consequence	•	in						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Gram Negative Bacteria Due to (or as a consequence of):									
	nd nd ransit	Examiner	that initiated events	c									
ó,	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as a	a consequence	of):							
8760,	fficate be executed g physician and s the burial-transit	dical		d									
9 ×	leath certific attending p for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					224	Date of dalis		
P.O. Box	leath atter I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐ Ectop 5 ☐ Other	ic pregnanc (specify)	У		230.	Date of deliv Month		
0	the d	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 ☐ Unknown		Stiller (Speedily)							
ω, -	uires that the de signed by the a	by PI	Part II. Other significant conditions	en în Part I.	23e. Did to	he cause of death?							
ğ	en sig	edt	End Stage Rena	Disease					1 🗆 🗅	res 2.1€N	o 3□ Pro	bably 4 ☐ Unknown	
၁၁	law re as be 2 sho	plet	Adult Failure to Thrive Syndrome 24a. Was an autonomy								24b. Were autopsy findings available		
The part of the								performed? death				o completion of cause of ? es 2 ☐ No	
Z I	ician: sertific ector,	Be	25. Was case referred to medical examiner?										
ot o	Phys this al dir	2	1 ☐ Yes 2 ₺ No 27. Manner of Death	CLE TO I	nt 2 ER/Ou	itpatient 3 Time of		445 Nursing no				fy)	
e .	ding h. After funer	tion	1. Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y, Year)	njury M	28c. Injur Worl	yat k? Yes 2 □No	28d. Describe ł	now injury oc	currea		
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	al or a after a after a bire	Certification: To	28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Inc.)									·	
i	ospita hours unera ly fille		29a. Certifier 1 Certifying I	Physician: To the best of	of my knowledge	e, death occur	red at the til	me, date and place,	and due to the	cause(s) and	d manner as	stated.	
:	To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s and manner stated.									to the cause(s)	
_	To the within 3 To the comple	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									Day, Year)	
			Buson	1111000	sarp	111	D002	26564		05/2	4/2011		
N	3		30. Name and address of person wh		,			N.E.			0010		
	Sta	e.	Susan M. Ginsbe	32. Registra	ar's Signature		ceet,	NE Wash:	ington,	DC 2	0010		
	Registra		31. Date filed (Month, Day, Year) MAY 3 1 2011	Cenua > S.	par	1							

DHMH 17 Rev 1/2001

			For	State of M	1arylan					ental Hyg	giene			
	ror.		■ State Registrar		Cer	tificate c	f Death		Reg. No. 2011 1955					
	Physicia	n/	1. Decedent's Name (First, Middle, I	-						2. Date of Dea Month May	ath Day	2011	3. Time of Death 6:05 P M	
	Medic	al	4a. Facility Name (if not institution, c	rothy			Mohai		a of Dooth	мау			0:03 P M	
1	Examin	er	Kline Hospic					. Airy	TOIDealli			ounty of Death Frederi	ck	
	Funeral		5. Social Security Number 6	. Sex 7. A	ge (In yrs. la	st birthday)	If Under 1 Y	ear If Und		8. Date of Birt	h	9. Birth	olace (State or Foreign	
	Director		220-72-7117	1 □ M 2 🖾 F	88	Yrs.	Months Da	ys Hours		$e^{Month}_{\bullet} 1^{Day}$, Year 923	3 Trin	idad	
70	low It	ı.	Usual Residence of Decedent 10a. State 10b. County		T 10c City	, Town or Lo	cation						10d. Inside City Limits	
he Marylan	a-fsh fied a	Director	Maryland Frede	rick	1.55.5.1,		Airy						1 😾 Yes 2 □ No	
	or 28 e noti	Dir	10e. Street and Number				10f. Zip Co	de		10g. Citizer	n of What Cou	ntry?		
With I	s 23a ust b	Funeral	12604 Moleswort	h Entrance				2177	1		Unite	ed Stat	es	
death	item:		11. Marital Status	Ever in U.S	. 13. \	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Black, White, etc.								
S affer	l", or xamir	d by		1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☑ Married If Yes, Give					fy:		Spe	ecify:	Indian	
	atura cal E	Completed	3 Widowed 4 Divorced 15. Decedent	16a. Dece	ent's Usual Occupation 16b. Kind of Business Industry									
2 2 2	an "n Medi	ldm	(Specify only highest Elementary/Seconday (0-12)	(Give	kind of work do O NOT use reti	one during mo	ost of working	g 17	TOD. KING	or Eddingoo III	adony			
	giene ler th t, the		5	College (1-4 or	0.,	Chil	dren's	Care '	Taker		Chi	ldcare		
2	tal H)	To Be	17. Father's Name (First, Middle, La	st)				18. Mo		First, Middle,		name)		
y y	d Mer mark natic		John Rupert 19a. Informant's Name/Relationship	(Time Dulat)						Unkno		04-4- 7:-	O- 4-)	
Sho	of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Sherina Mohamme		er							wn, State, Zip (ry, MD		
בי קו	Department of Healt Important; If item 2 any injury or other once,		20a. Method of Disposition		20b. Pl		sition (Name o		Da	ate	20c. Loca	tion - City or To	own, State	
armit Page 1	ant: If		1 Burial 2 Tremation 3 4 Donation 5 Other (Sp	□ Removal from Stat ecify)	.0		natory or other Cremate		5/25/	2011	Frede	rick, M	laryland	
Dall	Departr Importa any inju once,		21. Signature of Funeral Service Lic	ensee		22	2. Name and A		,			eral Ho		
	اة ية ك ت		/ourtney	Stauffer	7							rick, M	D 21702	
			23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications of cause ly one cause on each li	ed the death	. Do not ente	er the mode of	dying, such a	as cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death	
	ysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a Cu/	dio	pul	MON	nry	-CI	rres	T_	-		
	xaminer			Due to (or as	s a consequ	rice oi):	cir	+00	V 1	sise	v (2		2 5 Yrs	
		ner	Se ventially list conditions if any, leading to immediate	ence ot):										
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the Hospital or Attending Physician; The law requires that the death certificate be executed	hysician and the burial-transit	dical Examiner	resulting in death) Last	Due to (or as	s a consequ	ence of):							,	
Sate be	physic the b	edic		d										
	nding Ise as	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom-							230	d. Date of deliv	erv	
eath c	atter if for u	icia	in the past 12 months? 1 Yes 2 No	in the past 12 months?								Month Day Year		
the d	by the	Physician/Me	9 Unknown	9 L Unknown				1						
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scords,	een si ould l	Completed	ALZh	CIME			NJI				-		bably 4 Unknown	
	has b	nple		_						24a. Was autop	osy	24b. Were auto prior to co death?	psy findings available impletion of cause of	
F He	icate r, pag		25. Was case referred to medical							perfo 1 Yes	2 🗷 No	1 🗌 Yes	2 No	
Siciar	certif	o Be	examiner? 1 Yes 2 No	Hospital:	ations 2 🗆	EB/Outpotion		dhea		only one)				
Phy P	er death. ector: After this certificate has been signed by the attending pt by the funeral director, page 2 should be detached for use as th		This input of the state of the								, 1100P101			
endin	eath. or: Aft he fun	ficat	1 Natural 5 Pending 2 Accident Investiga	ition	ay, rear)	injury	М	work? 1 Yes 2	□ No	No				
Y Att	irecto irecto n by ti	Certificate:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of in	njury - At hor etc. (Specify)		eet, factory, of	ice	28	8f. Location (S City or Tow		umber or Rura	Route Number,	
	eral D				Con Lorent	- 1 1 45		Ai	d alasa and		use(s) and n	nannor ao etat		
Hos	within 24 hours after death. To the Funeral Director: After completed filled in by the funer	edical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of lurse Practioner: To the	examination	and/or inves	tigation, in my	pinion, death	occurred at the	he time, date a	ind place, an	id due to the ca	use(s) and manner stated.	
To the	within To the sompl	Σ	29b. Signature and title of certifier				29c. Lic	ense numbe	r			igned (Month,		
			Mushed B	igh n	/an	1, M.	DD	393	72		May	122	th 2011	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rashid Baghai Naini, MD 344 University Blvd., Silver Spring, MD 20901														
	2						ty Blv	a., Si	ıver S	pring,	MD 2	0901		
	Stat	e	31. Date filed (Month, Day Year)	2011 32. Hagist	trar's Signat	ure	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 2011 11:30 P M Nellie Frederick Miller Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris, Inc. Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Ye March 25, 1 🗌 M 2 😿 F Year. Country) Director 222-14-0256 96 1915 DE Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland must be notified at 10d. Inside City Limits Director MD Harford 1 X Yes 2 No Aberdeen 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 16 Crestmont Drive 21001 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 10 ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White "natural" Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) than. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) is marked other <u>Bookkeeper</u> Public School District Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ Walter Frederick Amanda Virginia Burkholder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Dianne C. Dacey/Daughter <u>6 Crestmont Drive Aberdeen, MD 21001</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other plant Delaware Veterans Memorial Cemetery 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) May 31, 2011 Bear, DE Signature of 22. Name and Address of Facility Spicer-Mullikin F.H. 1000 N DuPont Pky New Castle, DE 19720 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or co Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) END STAGE RENAL DISEASE Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of): ng physician and as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 X No for Month Pregnant at time of death by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy perform Yes 2 X No Division of Vital funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 X No Other: ္ဝ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 123 2011 ess of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKÍE JONES, TIMONIUM, MD 21093 State Registrar

21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Physician/ Day 2011 28 John Joseph McNulty Sr. 12:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Atlantic General Hospital Berlin Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCt • 5, 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Days Hours Min. Yrs 83 Director 206-20-4719 PA Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🖺 No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 11602 Atlantic Ave. 21842 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Year or Dates. 1 Yes 2 XNo Specify. "natural", Specify Completed 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) laryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Food Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Felix McNulty Mary McCabe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Atlantic Ave. Ocean City, MD 21842 Lucille McNulty- Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State First State Crem. 5-31-11 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Funeral Service (Cansee 22. Name and Address of Facility Surbage Funeral Home 108 William Street Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cau e on each ine Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of executed that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Box Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown Yes Unknown o signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performs 2 🗌 No 1 Tes B B of Vital 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 X No Other: ျှ Unpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after deatl To the Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the days of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier is of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 28/11 30. Name and address of person who o

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Elbert Maxwell Moran, Jr. 11: 10 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Regional Prince George's _dure If Under 1 Year If Under 24 Hrs Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Yea 1 🙀 M 2 □ F Months Days Hours Min Washington DC **Director** Dec 4 578-42-6946 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Greenbelt Prince George's Maryland 1 Yes 2 X No 10e. Street and Number ms 23a or must be n ŏ 10f. Zip Code 10g. Citizen of What Country? Funeral 20770 6201 Springhill Drive Apt 201 USA ו "natural", or item ledical Examíner ח 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Ty Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify 3 🙀 Widowed 4 □ Divorced Specify: White Completed Year or Dates.1951-1955 th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical! 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Equipment Typewriter Repairman Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental F Important: If item 27 is marked o any injury or other traumatic eve ပ Clara Bell Hodge Elbert Maxwell Moran, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6201 Springhill Drive Apt 201, Greenbelt, MD 20770 Anita Moran - Duaghter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) June 2, 2011 Cheltenham, MD Maryland Veteran's Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home Calvert P.A. Amanda M. Ergler 8200 Jennifer Lane, Owings, MD 20736 234 Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 No 9 Unknown sate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗒 Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed' Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Tyes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 Matural 5 Pending 24 hours after death Funeral Director: A Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💆 Certifying Physician 🔀 the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying yerse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certify 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IMA 0707 7300 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:30 PM CARLOS MURILLO May 22. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Ecuador 1 X M 2 □ Months Days Hours Min. (Month, Day, Sept.11 579-46-0411 **Director** Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits with the Maryland Examiner must be notified at 10c. City, Town or Location Director 28a-f 1 🗆 Yes 2 🔀 No Maryland Montgomery Germantown 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 18003 Mateny Road Apt. #200 20874 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 X Yes 2 □ No Specify: South American Specify: White "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l. Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "na any injury or other traumatic event than "na once." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) First Butler Japanese Embassy Murillo, Car Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Vincente Murillo Rosa Castillo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura M. Murillo (Wife) 18003 Mateny Rd. Apt. #200 Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State Alexandria, VA 4 Donation 5 Other (Specify) Metropolitan Crem. 21. Signature of Funeral Service Lice 22. Name and Address of Facility DeVol Funeral (M01116)10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequ Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown the 2 1 ☐ Yes ∠ ☐ 9 ☐ Unknown detached is been signed by to 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ANO certificate has page 1 Yes 2 No rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this (4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending injury nours after death.

neral Director: Aft
filled in by the fur 1 Yes 2 No М Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 23/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ahmed MD Georgia Ave \$203 Silver Spring MD 20902 10301 31. Date filed (Month, Day, Year) State 25 2011 Registrar

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#23a/bperMD,5/25/11; BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rubab March Day 2011^{Year} 21. Moledina 12:25P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Port Deposit 24 Remington Road Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖫 F Hours Junet 6, 1928 387-70-5122 82 Zanzibar, Tanzania Director Usual Residence of Decedent Fshow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cecil Maryland Port Deposit 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 Remington Road 21904 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 2 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT_use retired) Elementary/Secondar (2-12) College (1-4 or 5+) Housewife own home 18. Mother's Name (First, Middle, Maiden Sumame) Zainab Alidina Jaffer 17. Father's Name (First, Middle, Last) Dhalla Hirji Jaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fatema Rashid -daughter 24 Remington Road Port Deposit, Maryland 21904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
MD National Mem. Park 5/23/2011 20c. Location - City or Town, State 14 Burial 2 Cremation 3 Removal from State Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bonard V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the my e of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Betwee Onset and Dea Immediate Cause (Final Pmysician/ ONGESTIVE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1 month Atherosclerotic Heart Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month 4 Pregnant : 9 Unknown Pregnant at time of death sate has been signed by the page 2 should be detached g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate to the Funeral director, page qompleted filled in by the funeral director, page 2 No 1 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medica æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 2 🗀 🎇 ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 \sum Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0043375 2011 cause of death (Item 23a) (Type, Print) 35 8 Smit 31. Date filed (Month, Day, Year) State 25 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierre 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** (atherine 0d bert trlene 2011 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Westminster
Westminster

Vear I If Under 24 Hrs.

Min. Examiner Carroll Dove House If Under 1 Year Birthplace (State or Foreign Country), Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Pennsy Ivania 1 ☐ M 2 🗷 F 86 196-16-7769 June Director 10 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County item 27 is marked other then "naturel", or items 236 or 286-f show other treumatic event, the Medical Examilier must be notified at MD 1 ☐ Yes 2 No Carroll Director Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2153 Enoff Drive U-S. A. 2115 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "tay injury or other treumatic event, the Mad ORCE. Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Secretary 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Bernard Nunemaker Krumnine. 6. Lula 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5930 Great Star Drive Unit 302 Clarksville, Manylord 21029 Cheryl A-Jones Villing lifer 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 ■ Removal from State May 21, 2011 Everyreen (einstein) ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility tre. 321 Carlis le Street Cettyburg. PA 19325 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STROKE < 1 worth Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month for in the past 12 mon Day 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MENINGIONIA 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes 2 No Yes Hospitel or Attending Physiclan: 24 hours after death. Funerel Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) HOSPICE 2 7No 2 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 12011

mago

State Registrar 31. Date filed (Month, Day, Year)

n, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

fistrar's Signature

Businoss

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Year Physician/ May 27, Jennifer Lyn O'Toole 4:40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Woecester If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Aug. 2, 1969 . Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 220-88-0270 4] MD Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b County 10d. Inside City Limits 10c. City, Town or Location death with the Maryland Director 1 Yes 2 No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 155 A Captains Quarters Road 21842 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Manager Restaurant injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve Martin O'Toole Doris Ann Payne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2\,1\,8\,4\,2$ 19a. Informant's Name/Relationship (Type, Print) Albert Tobak- uncle A Captains Quarters Rd. Ocean City 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State First State Crem. 5-31-11 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign to e of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events law requires that the death certificate be executed resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗆 Yes 2 🗆 No 2 No Yes Division of Vital Hospital or Attending Physician: Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 27. Manner of Deat

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Yes 2 🗆 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Plurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>011</u> Physician/ а М Otterstetter May 2:23 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital Social Security Number 6. Sex 1 ☐ M 2 ☐ F Funeral Age (In yrs. last birthday, Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Country Germany Months Days Hours Min Sept. 20, ^{Year)}1939 Director 71 578-04-4328 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7420 Westlake Terrace, #610 20817 Germany 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? þ 1 Never Married 2X Married 72 hours after Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 to and Mental Hygiene.

7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Environmental Engineer Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anneliese Babette III1mer Karl Otterstetter ge 1 and 2 should be nt of Health and Mer t: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7420 Westlake Terrace, #610, Bethesda, MD 20817 Deni Teves Otterstetter/Wife altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore
permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State May 28, 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA Signature of Funeral Service Licenses 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) <u>Nvocardial Infarction</u>
Due to (or as a consequence of): Medical Examiner Coronary Ischemia Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury Hypertension burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Attending Physician: The law requires that the death certificate be Cerebrovascular Disease the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death the Ö signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No Yes 2 🔀 No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No Certificate: To 1 ☐ Inpatient 2 🛣 ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify) Division of the tuneral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No al or Attend s after death I Director: A Accident Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital thin 24 hours a Medical 29a. Certifier 1🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 13 and title of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed vause of death (Item 23a) (Type, Print)

Frederick W. Randolph, MD 8600 Old Georgetown Road, Bethesda, MD 20814

Registrar

31. Date filed (Month, Day, Year)

MAY 25 2011

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Streste

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 4a, 23b, e, 25, 27–28a-f, per me 8916 6-24-11 vt State of Maryland, Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Yea11 Day 27 Physician/ 1851 Vernon George Pursel Medical 4a. Facility Name (if not institution, give street and number)

General Hospital

Montgomery County Ceneral 4b. City, Town, or Location of Death Examiner 4c. County of Death 01ney <u>Montgomery</u> Sex 1 M 2 D F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) NV Days Hours Min 1 Mari 12 1936 Director 530-22-9352 74 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Highland MD Howard 10e. Street and Number 10f. Zip Code "natural", or items 23a or idical Examiner must be n 10g. Citizen of What Country? Funeral 20777 USA 12642 Scaggsville Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedor... Armed Forces? Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Divorced 4 Divorced permit. Page I and 2 should be filed within 72 hour.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur.
any injury or other traumatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specity only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Scientist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gertrude Batchelder Ralph Pursel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16174 Carrs Mill Rd Woodbine, MD 21797 Timothy J. Pursel/son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 5/31/2011 Hanover, Maryland 4 Donation 5 Other (Specify) Crematory 21. Signal of Funeral Service Lig 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. strai 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part J Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death O PATHY Choking Ph_sician/ ENCEPHAL -noxic Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated Examine CERTIFICATION APPROVED STAMPLICAL EXAMINER Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of). signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has autopsy performed? Yes 2 N 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) B examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 X W မ 1X Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred subject choked on bolus of 28b. Time of Certificate: 28c. Injury at After injury 5 Pending CNatural 1 Yes 2 K No 5-25-11 12:30p ^M Accident Investigation 24 hours after deat Funeral Director: food 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3308 Olney—Sandy Spring Rd. Olney, Md. determined Restaurant Medical 29a, Certifie 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) M Dogs 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Drive arey MD 10 egistrar's Signatur State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Sam M. Perrin May 2011 8:00 A^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's ManorCare Hyattsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 18, Social Security Number 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 - F 1926 Roanoke, Director 224-34-3969 85 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6500 Riggs Road 20783 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 X Yes 2 ☐ No Black, White, etc. 2 should be filed within 72 nours and the and Mental Hygiene. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 X No Specify: Yes, Give 3 \square Widowed 4 \square Divorced Year or Dates. 1949-53 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Maintenance Technician Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Unavailable Lucy McConkey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Jean W. Perrin / Wife 6500 Riggs Road, Hyattsville, MD 20783 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 5/29/2011 4 ☐ Donation 5 ☐ Other (Specify) |Alexandria, Virginia 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue 22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Uremia / Medical resulting in death) Due to (or as a consequence of): Examiner Renal Failure Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying -transit that the death certificate be executed Cause (Disease or iinjury Obstructive Uropathy that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Bladder Carcinoma IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? 2 🗌 No cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Terminal Dementia; Hypertension 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Failure to Thrive 24a. Was an Hospital or Attending Physician: The law 24 hours after death.
Funeral Director; After this certificate has autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🔀 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number D47867 May 27, 2011 address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

Zuniga, 31. Date filed (Month, Day, Year)

2011

4701 Randolph Road, #216, Rockville, MD 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JOSH 9.11 A.M. Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Takoma Park Montgomery 8. Date of Birth (Month, Day, Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Min. 578-38-5895 Months Hours Country) 91 Director Jàn ľ920 Usual Residence of Decedent if item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗌 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20002 Apt. #724 900 G Street, NE U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Completed by 1 Never Married 2 K Married X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 Divorced 4 Divorced Armv Year or Dates. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private 9th General Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Josh Palmer Matilda Burrough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances A. Palmer/ Wife 900 G Street, NE, Apt# 724, Washington, DC 20002 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 06/04/2011 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Washington National 22. Name and Address of Facility J.B. Jenkins Funeral Home Signature of Funeral Service Licenses 7474 Landover Road, Landover, MD 20785 23a. Part 1. Enter the disease e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failurg. List only one cause on each line. Immediate Cause (Final Physician/ Urosepsi disease or condition resulting in death) Medical Due to (or as consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to by as a consequence of) Severe use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical OYUN Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant g ☐ Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 After this certificate 1 Yes Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be 2 No မှ 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 🗆 No 24 hours after death. Funeral Director: A Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The critiquing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only or 29b. Signa 29d. Date signed (Month, Day, Year) ans 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shailendra Kumar M.D. 6510 Kenilworth Avenue Suite 2200 Riverdale, Maryland 20737 31. Date filed (Month, Day, Year) State 2011 MAY31 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 5 Physician/ May 2011 2:28p Christine Marie Pruitt Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country)
 MD 8. Date of Birth Social Security Number Funeral Days 1 □ M 2 🛛 F Months Hours Min 49 Yrs 219-84-0143 **Director** Aug Usual Residence of Decedent 10a. State 10b. County with the Maryland aţ 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 🗆 Yes 2 💢 No MD Cecil Conowingo 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the M. dical Examiner must be Funeral 21918 USA 5 Springway permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the M. dical Examiner muones. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 XMarried by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Customer Service Rep. Credit Card Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Emile Darchicourt Marie Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Springway Conowingo, MD 21918 Sidney Pruitt/ Husband 20a. Method of Disposition
1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5/2972011 cemetery, crematory or other place) T. Foard Funeral Home, P.A. 4 Donation 5 Other (Specify) Rising Sun, MD 21. Signature of ral Service Licensee R².T¹. Foard funeral Home, P.A. 111 S. Queen St. RisingSun, MD 21911 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on even line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury Examiner Due to (or as a consequence of) use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) ned by the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown for 5 Other (specify) Month Day Year Pregnant at time of death detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signe page 2 should be o 2 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy perform certificate ! 25. Was case referred to medical examiner?
1 ☐ Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 🗆 Inpatient 2 🕽 ER/Outpatient 3 DOA After this 27. Manner of D ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending Investigation Accident hin 24 hours at er deat the Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within To the 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

State Registrar 23a) (Type Print)

(Item

Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Jacqueline W. Quiggle Medical Mav 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 M 2 X F 86 Months Hours Min 7412-P19724 Director New York 102-20-7363 Usual Residence of Decedent or 28a-f show 10a. State within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director X☐ Yes 2 ☐ No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9707 Old Georgetown RD 20814 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygien is marked other th Homemaker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events. မှ Louis Whiton Collette Rither 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Quiggle/ Husband 9707 Old Georgetown Rd, Bethesda, MD 20814 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State National Crematory Falls Church, VA 4 Donation 5 Other (Specify) 5-23-2011 21. Signature of Funeral Service License 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Urinary Tract Infection Medical resulting in death) Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exam attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box (23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown detached P.O. à s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Records, 1 Yes 2X No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? certificate ! 2 X No 2 No Yes the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🗓 No မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident
Suicide work To the Hospital or Attendi within 24 hours after death To the Funeral Director: A 1 Tyes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide mpleted filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D71462 May 16,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

MAY 25 2011

Dan Davila, M.D. 8600 Old Georgetown RD, Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RAVER 1615 MA 16 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LINIVERSIT OF MARYLAND MEDICAL CONTER BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 Min. 68 09/19/1942 Director MD 218-40-0085 Usual Residence of Decedent 28a-f shov 10a State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Yes 2 No Carroll Westminster 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21157 39 Westmoreland St. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give 2XX No 72 hours after Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates. event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene, is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) University of Maryland Administrative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ethel Wilson Woodrow J. Raver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tim Raver/brother 1 and 2 s f Health item 27 MD20723-5721 10526 Twin Cedar Ct., Laurel, other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 🔲 Burial 🏂 Cremation 3 🗌 Removal from State 05/19/2011 Hampstead, MD 4 Donation 5 Other (Specify) Carroll Cremation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home (412 Washington Road, Westminster, MD lark 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Physician/ CARDIOMYOPATHY IDIOPATHIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in reclaim cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or se a noneaquerine of) Exami Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death the Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ coronary artery disease, chronic obstractive pulmenary 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an disease pulmonary hypertension, end-stage autopsy performed? Yes 2 No this certificate has Hospital or Attending Physician: The venal disease 1 Yes 2 No Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗷 No Hospital: Other: ပ္ 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident within 24 hours after death

To the Funeral Director, /
completed filled in by the f Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier WJL MO P25607 MAY 16 2011 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 21201 22 SOUTH GREENE ST BILGE KALYON

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 30, Physician/ Day 0 1 1 Year 3:15 AM Kellee Mitchell Reagin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Atlantic General Hospital Berlin 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year 1960 Country) 1 M 2 F Director Wash. 215-82-7493 March Usual Residence of Decedent 28a-f shor item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 110 Franklin Ave. 21811 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 0 1 Never Married 2 Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", If Yes. Give 3 Divorced 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ann McHenry Harold Mitchell . Page 1 and 2 shou tment of Health and tant: If item 27 is n 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Franklin Ave. Berlin, MD 21811 Timothy Reagin-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2 🗗 Cremation 3 ☐ Removal from State 6/1/2011 | Millsboro, 4 Donation 5 Other (Specify) First State Crem. f Funeral Service 22. Name and Address of Facility Burbage Funeral Home 21. Signatur 108 William Street Berlin, MD 21811 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Due to for as a consequence of) disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown nis certificate has been signed by i director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 M Unknown Recor Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed' this certificate 1 Yes 2 No 1 ☐ Yes 2 🗷 No **Division of Vital** or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗷 No မ 1🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at within 24 hours atter used...

To the Funeral Director: After the reserved filled in by the funeral properties. 28d. Describe how injury occurred 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Reagin, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30/2011

BA 8

State Registr<u>ar</u> 31. Date filed (Month, Day, Year) 32. Registrar's Signature

W

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 31

Die A farks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day Physician/ 18 2011 May Rita Rugur Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 3510 Forest Edge Drive Silver Spring 8. Date of Birth (Month, Day, Yea Sept. 30, 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday, **Funeral** Months Hours 1 ☐ M 2🛣 F 86 Canada Director 083-24-4974 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3510 Forest Edge Drive 20906 USA items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. SpecifyWhite If Yes, Give "natural". 3 X Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Retail Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည James McLennon Alice Gale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sharon Whitt/Daughter 4809 Eades Street, Rockville, MD 20853 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 6/21/2011 Arlington National Arlington, VA 4 Donation 5 Other (Specify) Francis J. Collins Funeral Home Inc. Signature of Funeral Service Licepsee MO 1503 500 University Blvd. W., MD 20901 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Squamous Cell Carcinoma of the Lung Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 🗌 Yes 2 🗎 No within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 1 ☐ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 🔲 Yes 2 No ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5 Pending 1 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide pleted filled in by determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 = only one 29b. Signature and title of certifier 0 D55522 May 19, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Robert H. Gerard, MD

MAY 25

31. Date filed (Month, Day, Year)

Registrar's Signat

1500 Forest Glen Road, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 JOHN REIDER 5:50 РМ Medical 4a, Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WORCESTER ATLANTIC GENERAL HOSPITAL BERLIN If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Min. FEB. 13, Year) 1 🕅 M 2 🗆 F Months Days Hours MARYLAND 215-32-2115 76 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 ☐ Yes 2 🛣 No SUSSEX SELBYVILLE DELAWARE 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? ō 23a Funeral 19975 USA 38960 SEAGULL ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married ō þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 'natural", 3 ☒ Widowed 4 ☐ Divorced WHITE Completed 1955-58 Year or Dates. injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION CONTRACTOR 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ MAGZEMEN REIDER SR. **ELEANOR** JOHN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh.
Department of Health and
Important: If item 27
any injure. P.O. BOX 82, FOREST HILL, MARYLAND 21050 CATHERINE A. WARD/DAUGHTER Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 4 Donation 5 Other (Specify) CREMATORY OF DELMARVA 5/26/11 DELMAR, DELAWARE 21. Signat re 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 24 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line, Interval Between Onset and Death Immediate Cause (Final A Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (ow as a consequence of): Q Cause (Disease or liniury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown the 9 I Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed lipage 2 should be det Completed by 1 Yes 2 No 3 Probably 4 Abnknown Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 \(\subseteq \text{Yes} \) 2 🗌 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 1 29c. License number 29d. Date signed (Month Day, Year,

Registrar

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death (Item 23a) (Type, Print)

32. Registrar's Signature

of person who completed cause

Year!

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1755 Clara Rossbach Mary Month-Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Peningula Regional Medical Cente Nicomica If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 216-12-8393 Days Months Hours Min 89 Director 09/22/192 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 715 Richwil Drive 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Martin Gamber Laura Slade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Rossbach/son 715 Richwil Dr., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balisbury Crematory 5/24/2011 Salisbury, MD 21. Signature of Funeral Service Licensee ²²HOTTOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a, Part 1, Enter the disease, or complications that caused the death, Do not enter the mode of dving, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure, List only one cause on each line, Immediate Cause (Final Physician/ OPD disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last physician sthe burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Uknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an sate has t page 2 s autopsy performed Yes 2 certificate | director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral in 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of gertifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Mac 1700 William David Ritchie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Year. Days Hours Months 1 🔀 M 2 🗆 F Louisiana 462-80-3642 60 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Marylan 10a State 10b County iral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No Director MD Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21045 8819 Shining Oceans Way USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 1973— 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ▼Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: White 2 3 Widowed 4 Divorced 1999 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DISA 12 Operations Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RC Ritchie Anna Zimmer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8819 Shining Oceans Way, Columbia, MD 21045 Deborah N. Ritchie/Wife 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Arlington National Cemetery Sept. 7, 2011 Arlington, VA 21. From ture of Funeral Fervice Licensee 22. Name and Address of Facility alkant Murphy FH 4510 Wilson Blvd. Arlington, VA 22203 une 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 4therosclerote /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence off an, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Literal LULLLam Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?
1 ▶ Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1) 0068107 2011 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Coton Avenue Baltimore, MD 21229 Villarreal Alejandro, MD 900

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ $20\overset{\text{Year}}{1}$ P^{M} May 6:50 Louis Anthony Smalarz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sykesville Carroll 7309 2nd Avenue If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral 1** M 2 □ F Months Days Hours Min Jan 3, 1931 Yrs. Massachusetts 038-18-7336 80 Director Usual Residence of Decedent show 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 🗌 Yes 2 🗐 No MD Howard Woodstock 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or Funeral 11165 Chambers Court Bldg 9C 21163 United States ural", or items 2 I Examiner mus permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 'natural", Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other to r traumatic event, the Owner Screen Enclosure Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Michael Smalarz Stella Supirski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 11165 Chambers Ct. Bldg 9C Woodstock, MD 21163 <u>Janice Yvonne Smalarz/wife</u> other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Date 1 Burial 2 Cremation 3 Removal from State Ardent Crematory 5-27-2011 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 21. Signature of Funeral Service Licensee R4homas uanita 1112 Old Columbia Pike Ellicott City, MD 21043 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final AMYO Ph_sician/ TROPHIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) s been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) Month Day Year 1 Yes 2 g g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page 2 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 XNatural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the within 2 29b. Signature and title certifie 29c. License number 29d. Date signed (Month, Day, Year) PS7722 May 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 Greene Tree Rd Pikesville, MD 21208 EONARD RICHARDSUN M.D. 31. Date filed (Month, Day, Year) MAY 3 1 201 State Barkel Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Arrend For State of Maryland / Department of Health and Mental Hygiene State #'s10d.10e.19b.20b.PerFHP306-1-11cr Certificate of Death Reg. No. Reg. No. 2. Date of Death Montina y I. Decedent's Name (First, Middle, Last) Physician/ 2011 11:01a^M Stewart Juanita Smith Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Cheverly Prince Georges Hospital 9. Birthplace (State or Foreign Country) Washington, DC 5. Social Security Number 7. Age (In yrs. last birthday) 24 Hrs Min. 8. Date of Birth **Funeral** 1 🗆 M 2 😾 F Days Hours 1934 76 Director 577-44-9376 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s dical Examiner must be notified 1 X Yes 2 Alo DС Washington 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Kansas Funeral 20011 United States 5606 Kanas AVE NW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced Black the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Public telephone operator 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental H permit. Page 1 and 2 should be file Department of Health and Mental Important; If item 27 is marked of any injury or other traumatic eve ٩ Harryday Walter Stewart Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beltsville, MD 20705 #301 Reid Daughter 11336 Cher rd Tanya 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) $5/\frac{24}{2011}$ Wash, DC Glenwood Cemetery 22. Name and Address of Facility
Wesley Chavis III 21. Signature of Funeral Service Licenses any in once, Funeral Service INC 10684 Southern MD BLVD Dunkirk 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of). burial-transi resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 L Fetal uea Pregnant at time of death ned by the atter in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to þ 2 IPNo 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, To the Hospital or Attending Physician; The law requires 1 🗌 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion death?
1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 **1** No 1 🖫 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ this 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Director: After in by the funer Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) within 24 hours a Medical 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, diress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician/ Month **May 201** Year Isiah Shaw, Jr. 24, 0800 hrs/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Prince Georges Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 1925 Social Security Number **Funeral** Sex 1 XM M 2 □ F Hours September 11, 85 Tennessee 414-42-3891 Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location Director be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States or items 23a 20002 1629 Trinidad Avenue, N. E. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces? US Army
1 X Yes 2 No Dec. 1943
If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates. Jan. 1946 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Smithsonian Institution mentary/Seconday (0-12) College (1-4 or 5+) Commissary Worker The National Zoo 8th grade Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I ဂ Ethel Batchelor Isiah Shaw, Sr. 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health at Important; If item 27 is any injury or other trad 1629 Trinidad Avenue, N.E.; Washington, D.C. 20002 Dorothy Mae Rhodes-Fields Shaw 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 3, 2011 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State Quantico National Cemetery Quantico, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R. N. Horton Company Morticians, Signature of Funeral S Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CAP-DIAL APPHYTHMIA Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** EPS1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequ or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ę Year Pregnant at time of death 5 Other (specify) detached 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 🗌 Yes မ 1- Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 5 Pending 1 Natural nours after death.

neral Director: Af filled in by the full 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. e cause(s) and mainte.

29d. Date signed (Month, Day, Year)

1-5-20/ 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number

State Registrar person who completed cause of death (Item 26a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mayonth 26, 2011 9:15 Steinhauser Reinhard Henry Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles 8270 Fairgrounds Rd. LaPlata 5. Social Security Numbe Funeral . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min (Month, Day, 9. Birthplace (State or Foreign Days 1 🛛 M 2 🗆 F Months Country 1 and September 24,1930 80 Director 220-28-5201 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Charles La Plata 1 🗆 Yes 2 😿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8270 Fairgrounds Road Examiner must 20646 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black, White, etc. "natural", or 1 Never Married 2 Married within 72 hours after þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: 3 X Widowed 4 Divorced Completed White Year or Dates i and 2 should be filed within 72 hours f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver 8 Food Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Reinhold Steinhauser Freida Anna Neibergall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori Weedon/Daughter 1001 Sylvan Turn, Newburg, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 6/7/2011 Cheltenham, Maryland 21. Signature of Eune al Service Lice M01458 Arehart-Echols Funeral Home, PA any O. Box 567 LaPlata, Md. _20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 10 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be as the t IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death detached q 🗌 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No · Hospital or Attending Physician: 7 24 hours after death. · Funeral Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 2 🗶 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? Accident Investigation 2 🗌 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 29b. Signature and title of certific 29c. License number May 26, 2011

RBIOT State

Box (

Records.

Division of Vital

DHMH 17 Rev 7/2009

Registrar

30. Name and address of person

31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TMEZ 0847M ORGE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1, M 2 D F Days Hours Min. South Dakota 0872271943 Director 213-42-5941 67 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🗓 No Prince George's Bowie 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral U.S.A. 16507 Governor Bridge Road #103 20716 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) cartographer U.S. Government Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ Haze1 Marie Walker Same1 George Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16507 Governor Bridge Rd., #103, Bowie, MD Roberta J. Samel, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 05/22/2011 Alexandria, VA Signature Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disea shock, or heart failure. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ DEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner KLEBSIQLA Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ANGIO CARCINOMA To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sempleted filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မြ 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of celtifie 29c. License number 20 KW who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AY 25

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month 24, 2011 2:30 A M Denis Edward Snyder May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4450 South Park Avenue #1210 Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday)
72.73 Yrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 134-28-9040 1**X** M 2 □ F New York Director 03/09/1938 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show 'natural", or items 23a or 28a-f shov dical Examiner must be notified at tx Yes 2 No Chevy Chase Director MDMontgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 United States 4450 South Park Avenue #1210 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Y Yes 2 No 1962-If Yes, Give Year or Dates: 1969 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 2 3 Widowed 4 Divorced 1969 Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Consultant Census Bureau 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian Litvach ပ Joseph Snyder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raquel Snyder / Wife 4450 South Park Ave. #1210 Chevy Chase, MD 20815 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 5/26/2011 Falls Church, VA 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licen-5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the diserse, or complications u at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur.) List only one caus 4 n each line. Immediate Cause (Final 5 Minutes **Physician** Myocardial Infarction resulting in death) /Medical Due to (or as a consequence of) Examiner 10 Years Hypercholesteremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed 17 Years physician and sthe burial-trans Diabetes Mellitus Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as the attending IF FEMALE esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy õ in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by should be Congestive Heart Failure 2001 1 ☐ Yes 2√□ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2: autopsy performed? 1∐ Yes 2∏ No Division or Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕏 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 🔲 Inpatient 2 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation (Month, Day Year) Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident the f within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide ö the Hospital 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 24, 2011 D0037678 30. Name and orders of person who completed cause of death (Item 23a) (Type, Print)

James F. Mackin MD 5454 Wisconsin Ave. #675 Chevy Chase, MD 20815

State Registrar 31. Date filed (Month, Day, Year) **MAY 25 2011**



			For State Registrar	State	of Marylan		artment o <i>tificate d</i>			-	giene Reg. No.	W Cappedino 4th	18693	
ì	Physici /Medi		Decedent's Name (First, Midd Sylvia	Schreiber						2. Date of De May 19		Year	3. Time of Death	
	Examir		4a. Facility Name (If not institution Bedford Court	on, give street and nu	ımber)		4b. City, Tow Silver					4c. County of Death Montgomery		
	Funeral Director		5. Social Security Number 578-32-6238	6. Sex 1 ☐ M 27 F	7. Age (In yrs. 92	last birthday) Yrs.	If Under 1 Y	ear If Und	er 24 Hrs. Min.	8. Date of Bir 01/06/	th Y9 I 9	9. Birthp Cour Wash:	place (State or Foreign ntry) ington, DC	
	show show	٥٢	Usual Residence of Decedent 10a. State 10b. Count MD Mont	y gomery		y, Town or Lo lver Sp						1	10d. Inside City Limits 1 → Yes 2 → No	
	death with the Maryland me 23a or 28e-f show rinust be notified at	Directo	10e. Street and Number 3700 Internation	onal Dirve	#254		10f. Zip Coo	de 906			10g. Citizen of What Country?			
	o within 72 hours after death with the Marylan jiene. Then "natural", or lieme 23a or 28e-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status	1. Marital Status 1						pecify Yes or No Rican, etc.)	14.	United States 14. Race - American Indian, Black, White, etc. Specify: White		
	e riled within 72 hou al Hygiene. I other then "naturs vent, the Medical E	Completed	15. Decede	nt's Education est grade completed) (1-4or 5+)	(Give life. L	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary					16b. Kind of Business/Industry US Government		
	ges 1 and z should be filed to death and Mental Hyg if item 27 is marked other or other traumatic event,	To Be C	17. Father's Name (First, Middle George Shuman	, Last)		1,				e (First, Middle, Zippers	, Maiden Sun			
Mar	alth and h		19a. Informant's Name/Relation Faye Summers		r					al Route Number				
	permit. Pages I an Department of Heal Importent: If item 2 any injury or other once.		20a. Method of Disposition 1		State Jude	Place of Disponentery, cren	sition (Name on attory or other at a Gard	f place)		Date 24/2011	20c. Location	on - City or To		
Dallillo	Departn Departn Importe any inju		21. Signature of Funeral Service	Licensee M	01163		Name and Adamsk			Memoria Pike Ro	1 Char	pels In	8 852	
	hysician /Medical		23a. P. 11. First the control of the	or complications that st only one cause on a. Due to	caused the deat each line (or as a conseq	ERTE	er the mode of	dying, such	as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
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0,00,	physician and street the burian and street t	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseq	uence of):								
O. DOX OR	within 24 hours after death. To the Furnarial Directors After this certificate has been signed by the attending placement of the funeral director, page 2 should be detached for use as the state of the funeral director, page 2 should be detached for use as the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1□Live 4□Preg	23c. If yes, outcome of pregnancy 1						23d.	Date of delive Month	ery Day Year	
Ido, r.	n signed by uld be detac	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to											
The law soon	cate has been si page 2 should	Completed										prior to con death?	psy findings available impletion of cause of 2 No	
Dyroiclan	his certifi	To Be	25. Was case referred to medic examiner? 1 Tyes 2 No	Hospital: 1		ER/Outpatien	t 3□ DOA	Other .		h <i>(Check only c</i> ome 5 Resid		Other (Specify	y)	
o confined	in 24 hours after death. The Funeral Director, After this certificate himpletely filled in by the funeral director, page	Certification:	27. Manner of Death Natural 5 Pend 2 Accident invest 3 Suicide 6 Could	tigation	of Injury oth, Day Year)	28b. Time of Injury	М	njury at Work? 1 □ Yes 2	□No	28d. Describe I				
	ours after of and Directified in by		'4 Homicide deter	mined 286. Plac build	e of Injury - At he ling, etc. (Specif	y) 				City or Tov	on (Street and Number or Rural Route Number, r Town, State)			
the Hoe	thin 24 ho	Medicai	(Check only one) 29b. Signature and title of certifity		e best of my kno casis of examina nner stated.	tion and/or inv	estigation, in n	e time, date ny opinion, d ense numbe	eath occur	red at the time,	date and plac	manner as si ce, and due to gged (Month,	the cause(s)	
ř	5		· man	e	M.	D .	1	57	213	3	5	20)	1	
	C.		30. Name and address of person 31. Date filed (Month, Day, Year	AVE 9	055 (chevy	holer	driv	e	Ellice	ettu	ry M	1 2 10 42	
	Sta Registr	34	NAY 25 2	011 Sener	Registrar's Signa	par	J.							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Zelia Ree Hines Troxler 25, 201Ĭ May 4:30 A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 1934 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 X F Dav. Yea Hours Director 577-56-2533 76 North Carolina Ĩ3. December Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits or 28a-f sl notified Maryland 1X Yes 2 ☐ No Prince Georges Hyattsville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be i Funeral 900 Fair Oak Avenue 20783 United States items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 🗶 No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "natural", or iter Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 XWidowed 4 ☐ Divorced Specify: Completed Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Potomac Electric Elementary/Seconday (0-12) College (1-4 or 5+) filed within tal Hygiene. the Housekeeper Power Company 10th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever Thomas pe Hines Margaret Archie and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Troxler Clark (Daughter) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 900 Fair Oak Avenue; Hyattsville, Maryland 20783 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 3,2011 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quantico National Cemetery Quantico, Virginia 21. Sonatur, or Juneral Service 22. Name and Address of Facility R. N. Horton Company Morticians, Janoel Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph sician/ SEPSIS disease or condition Medical resulting in death) Examiner NEUMONIA Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine CERIBRO VODUNIONE STROKE The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events sician and burial-trans resulting in death) Last attending physician for use as the buria Physician/Medical DIGBETES MEZLITUS Division of Vital Records, P.O. Box 68760 IF FFMALE ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 🔲 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 U Other (specify) the detached g X Unknown g Unknown ģ been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D46998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEWM TER MD 3415 HAMMERM ST HYATISVILLE MD 24782 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 32. Regist ar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ohn Sterrett Tosh	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 20 8595										
Physician		2. Date of Death	n	3. Time of Death							
Medical Examine	John Sterrett Tosh Sr.										
	3121 Jacob Tome Highway Rising Sun	70	Cecil								
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.		F	Birthplace (State or oreign							
Birector	214-36-9435 1_XM 2_F 82 Yrs.	Dec. 22 1928 Country) MD									
ий	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits							
p of	MD Cecil Rising Sun			1 Yes 2 No							
Maryland 28a-f show	10e. Street and Number 10f. Zip Code	10	g. Citizen of What								
the Maryland is or 28a-f sh	3121 Tome Highway 21911		USA								
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be neithed at secon	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp			merican Indian, Black,							
or death with	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, e	tc.							
s after ral", o			Specify:	White							
hours			16b. Kind of Busin	ess/Industry							
7 3 = 1	Elementary/Secondary (0-12) College (1-4 or 5+)	,		_							
15-0036 filed within 72 hour Hygiene. d other than "natu t, the Melical Even Compulated	17. Father's Name (First, Middle, Last) Farmer 18. Mother's Name	/First Middle M	Family	Farm							
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AD 21215 2 should be file 1 and Mental H 27 is marked of matic event, etc.		tural Route Numb	ber, City or Town, S	State, Zip Code)							
MD 2 d 2 shoul lith and M n 27 is m numatic	Joanne Tosh / Wife 3121 Tome Highway Ris	ing Sun.	MD 2191	1							
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date / 2011	20c. Location - Cit								
Pager onent o	4 Donation 5 Other Specify: West Nottigham Cemetery	/ 2011	Colora,	MD							
Baltimore, permit. Pages 1 ar Department of Hea Important: If ite	21 Simplure of Funeral Service Licensee 22 Name and Address of Facility	Uomo D									
	R.T. Foard Funeral 111 S. Queen St. R.	ising Su	in, MD 21								
Physician Medical	3a. Plant i. Enter the disease, or domplications that caused the death. Do not enter the mode of dying, such as cardiac or fallure. List only one cause on each line.	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and							
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Death							
	Sequentially list conditions b.										
	if any, leading to immediate pause Enter Underlying Course Due to (or as a consequence of):										
1 0	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
O, e be execu sician and burial - tra	UNPENDED										
lox 6876(eath certificate attending phys for use as the b	IF FEMALE: 23b. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnan	23d. Date of del Month									
Box 6876 death certificate the attending phy of for use as the b	Pregnant at time of death 5 Constant	icy	Month	Day Year							
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tal Recidini: The certificate rector, page	25. Was case referred to medical 26. Place of Death (Check of	nly one)									
Physical direction	1 Yes 2 No No Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing		Residence 6 🗸 C	Other, Scene							
n of ding Ph.h.	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Yaar) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe ho	ow injury occurred								
SiOr Attend r death ector: by the	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	006 1									
Division of Vital Records, P.O. spital or Attending Physician: The law requires that thous after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detac. Certification: To Be Completed by F.	Suicide 6 Could not be determined (Specify)	or Town, Sta		r Rural Route Number, City							
Hospi 24 hou Funer ely fil		due to the cause	(s) and manner as	stated							
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the behalfed for use as the behalfed.	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.										
F 3 F 3	29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)							
1	O.C.M.E.		May 29, 2011								
6	30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Ba	altimore MAD	21222								
State	31 Date filed (Month Day Year) 32 Registrar's Signature 4	aitimore, IVID	- L 1223								
Registra	MAY 0 4 2011 A L L										

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 May 23. Ruby Sarah Tyler <u>6:</u>45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | (Month, Day, Year) | Min. | (Month, Day, Year) | March 5, 1924 Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 | \$ Director 505-26-4772 87 Iowa Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 This No Calvert Lusby Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20657 12161 Preston Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces Black, White, etc. ğ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 W No Specify If Yes, Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary Roofers Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Underwood Clara Shoeppner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 12161 Preston Drive, Lusby, MD 20657 Spouse other 1 Robert R. Tyler / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 05/27/2011 Leonardtown, Maryland 21. Signature of Funeral Service Vicense 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Detween and Death Immediate Cause (Final disease or condition resulting in death) Physician/ 0 Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a conseque re of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Other (specify) Day Year 1 L Yes 2 9 Unknown conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 3 Probably 4 □ Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performa 25. Was case referred to medical 26. Place of Death (Check only one) examiner? tital:
1 Inpatient 2 □ ER/Outpatient 3 □ DOA
28a. Date of injury
(Month, Day, Year) | 28b. Time of injury
(Month, Day, Year) | 28c. Other: ၉ 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of De 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number. completed filled in by determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I and title of certi 29b. Signature 29c. License number Date signed (Month, Day, Year) on who completed cause of death (Item 23a) (Type, Print) and address of per dRW 10 31. Date filed (Month, Day, 22. Registrar Signature State 25 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ruth Redden Taylor 2037 May 21, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 29, 1932 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗷 F Hours Maryland Director 212-66-1401 78 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Worcester **Girdletree** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3501 Snow Hill Road 21829 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 KWidowed 4 Divorced Completed white Year or Dates permit. Page 1 and 2 should be filed within 72 hours popartment of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Farm 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Milton M. Baker Marian Thelma Esham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda R. Martin (daughter) 401 William Street Berlin, MD 21811 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Springhill Cemetery May 25, 2011 Girdletree, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Home sh.ent 2110 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 13 Esat Grove Street Delmar, DE Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 4 inte Coronary disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Records, P.O. Box 68760 08/29/1932 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death the cate has been signed by page 2 should be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 📝 No ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

1100

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Registrar

31. Date filed (Month,

00063253

for west Market St. Snow Hill, MD 21863

Ernest all

2 4 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ennest Gibb Ja ne. 2

Tue or

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Helene G. Vance May 22, 10:20 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 319 Roberts Mill Road Carroll Taneytown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🕱 F Davs Hours Feb 4, 1924 87 Maryland Director Yrs. 216-20-6859 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Taneytown Maryland Carroll 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21787 6450 Taneytown Pike USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. 6 Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: white "natural", 3 Wildowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Personnel Investigator Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Galczynski Wladyslawa Gutowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 Roberts Mill Road, Taneytown, MD 21787 Wanda G. Rhodes, sister 20a. Method of Disposition 20b. Place of Disposition (Name of NewneSt crematosepher pace) 20c, Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 5/26/2011 4 Donation 5 Other (Specify) Cemetery Emmitsburg, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 200 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death nock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ des disease or condition resulting in death) (ancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Year be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 2 🗆 No Yes 2 No 1 Yes Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? sister's Home Hospital Other: 2 100 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Manner of Death Natural 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work' 1 🗌 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier WJL 21204 Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 6701 N. Char 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Viens Physician/ Ervin Norman 18:58 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hicomile 546136419 If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday, 578-16-3184 1 **X** M 2 □ F Months Hours Min 06/24/1921 New Hampshire 89 Director Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 Yes 2 X No Somerset Crisfield Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21817 3665 Freedomtown Road 12. Was Decedent Ever in U.S Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. þ 1 Never Married 2 X Married 72 hours after Maryland 21215-0036 1 Tes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Fyar Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Entrepreneur Business æ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ဂ္ Flora M. Chagnon Edward Dewey Come 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 3665 Freedomtown Rd., Crisfield, MD 21817 Elaine Viens/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Eastern Shore of MD
Veterans Cemetery 1 🛮 Burial 2 🗌 Cremation 3 🖵 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/23/2011 Hurlock, MD Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licenses Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Priysiciani new Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury that initiated events resulting in death) Last tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63199 20/11 30. Name and laddress of person who completed cause of death (Item 23a) (Type, Print) E Carroll St. Salisbury MD. P. R.M.C MD 100 00 Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiefie Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 24, 2011 5:30 PM May Jocelyne H. J. U. White /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Manor Care Wheaton Wheaton . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/12/1943 5. Social Security Number 124–46–3148 Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 🔀 F Yrs. Chaumont, France Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show ortant: If Item 27 is marked other then "netural", or Items 23s or 28s-f shov injury or other traumatic event, the Mudical Exercities must be notified at Yes 2 No District of Columbia DC Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20017 4830 South Dakota Ave NE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or item eny injury or other traumatic event, Item Medical Education 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Caucasian ģ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) Education Teacher 12 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Perrino Jean Uhl Madeline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington, DC 20017 4830 South Dakota Ave NE Andrew N. White III (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 6/1/2011 Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATOR **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte Year in the past 12 months? 1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ tNo 3 ☐ Probably 4 ☐ Unknown been : 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this Hospital or Attending Physical
 24 hours after death.
 Funerel Director: After this letely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 24 hours a 28a Certifier Cartrying in hydician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and marrier as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) (Check only one) ţ within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

9801 GEORGIA AVE SUITE 227, SILVER SPRING. EMURT

30. Name and address of rerson who completed cause of death-Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Re Completed by Elineral Director	2	19a. Informant's Na												y or Town, State,		
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ital Recision: The scerificate rector, page		25. Was case refer	red to medical						26.Place	of Death (Ch	eck onl	y one)				
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ding Ph		27. Manner of Deatl 1 Natural	h 5 Pending	28a. [Date of Inju tenth, Day,Y	iry 'ear)	28b. Time	of Injury		ıryatWork? Yes 2 😿 No		id. Describe h			_	
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Division o oppital or Attending hours after death. neeral Director: Aft y filled in by the func.		3 Suicide 4 Homicide	6 Could n determi	ot be		eside		street, ractor), onto	January, oto.			tate) 5	501 Edge	ewood Dr.	
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To the Ho within 24 P To the Fun completely	<u>.</u>			ner: On the ba and mann		mination a	nd/or inves				ed at th	e time, date a		e, and due to the		
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R2	1	30. Name and address Pamela E. S						900 W. B	altimor	e Street, B	altimo	ore, MD 21	1223			
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DHMH 17 Rev 1/2001 OCME 2006

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Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day 21 20°1'1 Physician/ 10:10AM 05 Jacqueline R. Williams Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 E1kton Union Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Country) 1 □ M 2 🕱 F 0370871945 MI 66 Director 184-36-5404 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2 🏝 No Nottingham PAChester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 19362 Gray Horse Road, PO Box 510 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
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If Yes, Give Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Advertising Graphic Artist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Betty Marguerite Bryer ဂ္ Robert Alfred Patton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gray Horse Rd. PO Box 510, Nottingham, PA 19362 Jay W. Lord - companion 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition 05/2872011 cemetery, crematory or other place) 1 🗆 Burial 2 💹 Cremation 3 🗆 Removal from State Rising Sun, MD R.T. Foard Funeral Home, P.A. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. S. Queen Street, Rising Sun, MD 21911 ich 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final LOWER LOBE PHEYMONIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Esquentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed use as the burial-transit certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death 5 Other (specify) completed filled in by the funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires t 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 ____ death? 2 No 26. Place of Death (Check only one) Be Division of Vital 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No 유 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28c, Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 24 hours after death e Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 21/2011 HOSPITALLIT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELKTON, M.1) 106 BOW ST, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2011 Month **Physician** 23 8:15 A^M May June C. Wells /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Calvert Solomons Solomon's Nursing Center 8. Date of Birth (Month, Day, Year July 10, 1923 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours Seat Pleasant, MD 1 □ M 2 XX Yrs -577-26-4384 87 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evan it at must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director Huntingtown Maryland Calvert 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 20639 1005 Donna Lane Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 □No IfYes, GiveXX Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □ Yes 2 ☑ No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary C. Farr Emmett E. Saar 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hyattsville, MD 20781 5032 55th Ave. Michael Emmett Wells-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD June 1,2011 Maryland Veteran's Cemetery 22. Name and Address of Facility Lee Funeral Home Calvert P.A. 21. Signature of Funeral Service Licensee Amanda M. Ergler 5 8200 Jennifer Lane, Owings, MD 20736 mo1533 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Approximate Interval Between 20a. Part 1. Enter the disease, or com shock, or heart failure. List only Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscienatic Cardiovaenaman **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown 1 DYOSIS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an An alemia autopsy performed? 1 □ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 TNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title_of certifier 2.50653 5-23-2011 SURANA e MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN .C. 851-Deale 2075 Deale (Year) 25 2011 A 31. Date filed (Month, Day, State Registrar

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Mar	2 shouth and the shou		19a. Informant's Name/Relationship (Ty				_				-	or Town, State, Zi	p Code)
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m 0	Page hent of int; If in it is or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐		Cedar			other place)	:	7/2011	Suri	itland,	MD
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29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day Year) 32 Registrar's Signature	ਵ∄ੂ ਪੜੀ		(Month, Day, Year)		28d. Describe how injury occurred						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 070 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2017 Physician/ JOAN HESSON YOUNG PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Plata ivista Charle a Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth JUL 8, **Funeral** Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Months Days y 1923 187-18-7644 PENNSYLVANIA **Director** Yrs. 87 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD CHARLES WHITE PLAINS 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8199 BILLINGSLEY ROAD 20695 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give ■ 43 - 45 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 2 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed 3 Divorced Specify: WHITE Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER AT HOME 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) FRANCIS LEON HESSON ELIZABETH MC MEEKAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM A. YOUNG JR./HUSBAND 8199 BILLINGSLEY RD, WHITE PLAINS, MD20695 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 and Department of H 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON NAT.CEM UNK ARLINGTON, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 21. Signature of Funeral Servi License M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final hysician/ disease or condition resulting in death) Medical Due la for as a consequence of **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at d be detached for 9 Unknown er significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed Yes 2 N certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: ည 1 🔰 Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral . Mayner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending s after death. Natural 1 Yes 2 No the . Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Prectional: The basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Cheof Certifying Nurs best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29d. Date signed (Month Day, Year)

State Registrar

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(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 13,20116:48 a M Ronggui Zhu 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🗓 F Min. Months Hours July 18, 1935 China Yrs 315-11-8070 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Rockville Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2609 Northrup Dr 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2X No Specify: Chinese 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Professor University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Qiang Zhu Xianfu Wang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2609 Northrup Dr, Rockville, MD 20850 Eva Chin/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 🏋 Burial 2 🗀 Cremation 3 🗆 Removal from State Rose Hill Cemetery Whittier, CA 5-21-2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG CARCINOMA CELL disease or condition resulting in death) Due to (or as a consequence of):

Physician/ Medical Examiner

Physician/

Medical

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Completed by Physician/Medical Be Medical Certificate: To

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician:

Sequentially list conditions.	h									
cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to for se a consequence of,:									
resulting in death) Last	Due to (or as a consequence of): d.									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		☐ Ectopic pro☐ Other (spe			23d. Date of delivery Month Day Year					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to									
		_		24a. Was an autopsy performed?						
25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)						
1 Yes 2 No	Hospital: 1 Inpatient 2 I ER/Outpatie	ent 3 🗆 DO/	Other: 4 Nursing H	fome 5 Residence	6 ☐ Other (Specify)					
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		of 280	c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred						
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)										
(Check 2 \(\sumeq\) Medical Exam	sician: To the best of my knowledge, death iner: On the basis of examination and/or inve se Practioner: To the best of my knowledge,	stigation, in my	y opinion, death occurred:	at the time, date and plac	ce, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier	len	29c. l	D23308		Pate signed (Month, Day, Year) 44 - 13 - 201/					

State Registrar

RIEGO

6311 ROKKEPGE DN. BETHESDA, MD 20817 MD Registrar's Signat

woo completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Robert Physician/ 1:15 AM Ayella Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Randallstown Season's Hospice 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours March 23, 1955 PA 183-44-0321 56 **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State Director 1 Tyes 2 No MD Baltimore Catonsville 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code Funeral 21228 USA 201 Worthmont Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 😿 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.] þ 1 Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Community College of al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Associate Professor other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F is marked of Robert Ayella Betty Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Worthmont Road; Catonsville, MD 21228 Lepartment of Health an Important: If item 27 is n any injury or other Leslie Ayella 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Balto-Wash Crematory 6/14/2011 Laurel, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 2122 21. Signature of Fund al Service Lice Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Physician/ Thyroip disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of that the death certificate be executed and -tran Exal Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death?

1 Yes 2 No autopsy performed Jas this certificate or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 other Specify hospice 2 🗹 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA the Funeral Director: After thin pleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 Yes 2 No Investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MSRAjapalneM.D D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21209 NS Rajapa KSE, M.D 2835 Smith AV 203 31. Date filed (Month, Day, Year) 32. State

DHMH 17 Rev 7/2009

Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 1 4 2011

32. Registrar's Signature

Darke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 1227 PM ALAN BEACHEL 2011 JUN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOWARD COUNTY GENERAL HOSFITAL HOWARD PLUMBIA 5. Social Security Number If Under 24 Hrs. If Under 1 Year 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 X M 2 🗆 F Days (Month, Day, Year) 05/07/1952 217 62 7066 59 Director Pennsylvania Usual Residence of Decedent 28a-f shov be filed within 72 hours after death with the Maryland 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7458 Durwood Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant. If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Common Carrier Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ David Carey Beachel Violet Straub 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonia Elaine Beachel 7458 Durwood Road Dundalk, Maryland 21222 (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 😾 Cremation 3 🗆 Removal from State Conation 5 🗆 Other (Specify) ō permit. Page Department of Important: If any injury or Bayview Crematory Inc 6/18/2011 | Baltimore Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA Sign tu uneral Service Licens 1407 Old Eastern Avenue Essex Maryland 21221 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIOVASCULAR ARTERIOSCLEROTIC Medical resulting in death) Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated execute.) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hyperlipidemia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' eral Director: After this certificate filled in by the funeral director, pag 1 Yes 2 No 2 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔁 Natural 5 Pending work Accident
Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a Medical Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year, 05037 201 Attending MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PERLINE 5755 MICHAEL OM MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

JUN 1 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JUN Year Barnes Gilliland 7130 Maureen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F (Month, Day, Year) New York Months Days Hours 129-24-1522 Director 79 1931 Sept. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No NY Suffolk Deer Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 336 West 11th Street 11729 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 Yes : 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Suffolk County Elementary/Seconday (0-12) College (1-4 or 5+) Child Support Investigator Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Mellon Elizabeth Fenton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Fitzsimmons-Daughter 2820 Westchester Avenue; Oella, MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State B α lto-Wash.Crematory 6/11/20114 ☐ Donation 5 ☐ Other (Specify) Laurel, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Figure al Service Licen 1630 Edmondson Avenue: Catonsville 21228 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Healthcare associated Physician/ pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner TWW MO 20 MARCE 120 Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami The law requires that the death certificate be executed Bladder and -trans Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fruct Urinava Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hydronephnosic Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy performe death? Cardiomyonnthy this certificate 2 🖸 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ည 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1/ Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of co 29c. License numbe 29d. Date signed (Month, Day, Year) D00:43662 8,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WIWAM BUYE HOWAR CO HURP 300 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene* For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2 0 1 1 Month Physician/ :20 A M June Anna Belle Beckley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Charlestown Care Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Min. 1 □ M 2XXF Director 215-03-9804 92 1918 Maryland Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2XNo MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number Funeral 709 Maiden Choice Ln. Apt. U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes XXNo If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of College (1-4 or 5+) Elementary/Seconday (0-12) Secretary <u>Maryland</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Lena Belle White George Hebert Beckley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 615 Banyon Ave. Severna Park, MD 21146 Barbara Harrison / Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Faiths
Crematory & Char 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial XXI Cremation 3 Removal from State 6/14/11 Manchester, MD 4 ☐ Donation 5 ☐ Other (Specify) Chape 1 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature Ineral Service Licens 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ardiomyo disease or condition resulting in death) Medical Due to (or as a con y quince of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d, Date of delivery 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 2 g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should 24b Were autopsy findings available prior to completion of cause of 24a, Was an After this certificate has autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be 2 No မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deati To the Funeral Director. Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certific 0039297 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 711 Maiden Choice Lane Dr. Michael K. Ro

Registrar

31. Date filed (Month, Day, Year)

JUN 1 4 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ GEORGE BERBERICH June 2011 12:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) Maryland 1**X** M 2 □ F Dec. 7, Year)943 Months Hours 218-52-3567 67 Yrs **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits must be notified at Director Maryland N/A Baltmore City 1 X Yes 2 No 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1803 Thornbury Road 21209 United States items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Examiner Black, White, etc. or 1 X Never Married 2 Married þ 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Disabled Disabled Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George K. Berberich, Sr. Nannette Trott Department of Health and Inportant: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Smith / Sister 27 Regester Avenue, Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 06/14/2011 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ of merica Complications disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner weeks Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Fibrillation, mental retur dat 2 No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 🗌 Yes 2 No 2 Yes ours after death.

eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner2 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Cother (Specify) HOSDICP 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending ☐ Natural ☐ Accident work? 5 Pending 2 🖾 No night fell at Goop home Investigation 6 Could not be 5728111 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Group home 1803 Thombuy Rd, Baltimore, MD within 24 hours a To the Funeral I Hospital Medical 29a. Certifier completed (Check 29b. Signature and title of certifier D0070639 6/13/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patel 4105 Baltmore, MD 21204 701 Ncharles State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 18 per fh. 9916 6-14-11 yf.
State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2011 1:55 PM Virginia B. Bankston Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Prince Regional HOSPITA dure Jeorge -dure 6. Sex 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖾 Months Hours 219-12-4993 Aug. 12, 1924 86 Director MD Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 Yes 2 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? ms 23a oi must be Funeral with 3160 Gracefield Road, #1531 20904 items filed within 72 hours after death al Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 XXNo If Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white "natural", 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. s marked other than "I umatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Office Assistant AT&T 12 Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed thrent of Health and Mental Hyrant: If item 27 is marked oth njury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) William Barrett Goldie Unknown E. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 Bryan Road, Burtonsville, MD 20866 William Bankston/ Son Important; If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Pk June 11,11 Rockville, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A.
313 Talbott Ave., Laurel, Maryland 20707-4389 21. Signature of Funeral Service Licenses M00773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and empleted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Live Birth 2 Live Signal 4 Pregnant at time of death Year Month 5 Other (specify) 1 ☐ Yes ∠y 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 XNo Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မှ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver Spring, MD 20904 Puthumana, Gracefield Road oveen J. 31. Date filed (Month, Day, Year) State IIIN 14 Registrar

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Box 68760	e death certificate be executed the attending physician and thed for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent p in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	Ideath 3		ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year			
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Division of Vital Records,	To the Hospital or Attending Physician; The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	I Certificate:	3 ∐ Suicide 4 ☐ Homicide	6 ☐ Could not determine				eet, factory, o	ffice		28f. Location (S City or Tow		l Number or Ru	ral Route Number,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 10:45P. M June 8, Annie Louise Britt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hanover Anne Arundel 7720 Baggins Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Min. 1942 Virginia Hours July 26, 1 □ M 2 🗶 F **Director** <u>578-56-4007</u> 68 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Hanover Anne Arundel Maryland 10 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral United States 21076 7720 Baggins Road items ? n "natural", or iten ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3 x Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry 2 should be filed with...
afth and Mental Hygiene.
---rked other than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Federal Government Computer Analysis Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en Lucille Mills David A. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7720 Baggins Road, Hanover, Maryland 21076 Rebecca Britt-Laughery 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 14, ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Odenton, Maryland Crematory 21. Signature of Fun ral Service Licensee ^{22. Name and Address of Facility}
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 M01386 23a. Part 1. Buter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Carzinan disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, ne if any, leading to immediate cause, Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No for Day Year 1 Yes 2 4 9 Unknown Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page 2 performed certificate 1 ☐ Yes 2 🗷 No Yes 2 Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗆 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the P only one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 2 June 9, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DeLuca, M.D., 305 Hospital Drive, 2nd Floor, Glen Burnie, MD 21061 31. Date filed (Month, Day 32. Aligistrar Asignatus State 1 4 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ David George Babcock June 2011 6:37 pm M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium StellaMaris Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March 1(Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 🕱 M 2 🗆 F Months 49 Maryland Yrs **Director** 445**–**56–0804 10,1962 Usual Residence of Decedent 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 🗌 Yes 2 ᢏ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1618 Ellis Ct. 21015 U.S.A. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 atth and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical 12 yrs Courier 102,11 SUY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Thomsen Richard M. Babcock Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Babcock mother 1618 Ellis Ct. Bel Air, Md. 21015 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Jo cemetery, crematory or other place) 1 \square Burial 2X Cremation 3 \square Removal from State Atlantic Crematory 6-14-2011 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, 610 W. MacPhail Rd. Bel Air, Md. 2 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ LUNG CANC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exam and Due to (or as a consequence of) resulting in death) Last DAVID BABCOCK Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No After this certificate 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, i 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific la sm son who completed cause of death (Item 23a) (Type, Print) State 4 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year ENNETT VIRCTINIA UNE 2011 TO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Augsburg Asst. Living 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 12-19-1913 Yrs. Maryland 97 Director 212-10-2889 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland notified at Director Baltimore Md. 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 21207 IISA 6811 Campfield Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ö 1 Never Married 2 Married δ Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify "natural", 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Tate Engineering 12th Salesperson Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Estelle E. Klingenstein Carroll E. Joynes permit. Page 1 and 2 should be Department of Health and Menr Important: If item 27 is marke any injury or other traumatic traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
27 Tenby Chase Drive Newark, Del. 19711 19a. Informant's Name/Relationship (Type, Print) DTR. Nancy Jean Taylor Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, Parkwood 6-16-2011 Parkville, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service License 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncertains Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) nding physician use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) atter in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death the signed by t d be detach Part I<u>L **Other** significant conditions c</u>ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 24 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has I performed 2 No 1 Yes Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 5. Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 7. Manner of Death 28b. Time of Certificate: 28c. Injury at After 11 Natural 5 Pending injury ithin 24 hours after death.

• the Funeral Director: Aformpleted filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation 6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Number Frantianium To the basis of my line whospy, shell continued at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2859 mi SW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 SmiTH Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

JUN 1 4 2011

Darks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 06 2011 1:29P M Burington Helen Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Glen Burnie 129 South Meadow Drive 8. Date of Birth (Month, Day, Year) 03/30/1923 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) DA **Funeral** Days Min. 1 □ M 2 🗓 F Months Hours PA 88 Director 236-18-0952 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland bartment of Health and Mental Hygiene. Sortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director Anne Arundel Glen Burnie 1 Yes 2XXNo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21060 129 South Meadow Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1XXYes 2 \sum No
If Yes, Give Black, White, etc. 1 Never Married XX Married Completed by Baltimore, Maryland 21215-0036 ☐ Yes 2XX No White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tillie Peterson James O'Donnell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 129 South Meadow Drive Glen Burnie, MD 21060 Mr. Daryl Burington / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial XXX Cremation 3 Removal from State 6/14/2011 Glen Burnie, MD Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signatur uneral Se M01220 PA 1 2nd Ave SW Glen Burnie, MD 21061 Services, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, any one cause on each second secon Approximate Interval Between Oneet and Death 23a. Part 1. Enter the disea shock, or heart failure. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) o (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to lor as a conse juence of To the Hospitalior Attending Physician: The law requires that the death certificate be executed within 24 hours -fler death.

To the Funeral Trector After this certificate has been signed by the attending nhusician and the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed 21 1 Yes 1 Yes filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 125 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my principle of the cause of examination and/or investigation in my principle. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 29b. Signature and title of cortile 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of

31. Date filed (Month, Day, Year,

berson who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

			Please	Type or Print in Blac			_	_	
			For State	State of Maryland / D			lental Hygie	ne 2011	18720
			Registrar 1. Decedent's Name (First, Middle, Last,	1	Certificate of L	Jeath	Reg. 2. Date of Death	. No.	10760
	Physicia Medic	al		Herbert A.	Brooks		June 10	•	3. Time of Death 8:30A M
	Examin	er	4a. Facility Name (if not institution, give s Bradford Oaks	Nursing & Raha	b Cl	r Location of Death inton		Prince G	eorge's
	Funeral Director			Vu o 🗆 🗂	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 01/13/1	ar) Cou	nplace (State or Foreign ntry) A L
	Maryland 28a-f show atified at	rector	Usual Residence of Decedent 10a. State 10b. County Prince	George's	or Location	Upper M	Marlboro		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the s 23a or a	Funeral Director	10e. Street and Number 9707 Cedar Cr	est Way	10f. Zip Code	20774	10g	. Citizen of What Cou US	
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ ★es 2 □ No Navy If Yes, Give Year or Dates.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, Puerto I	14. Race - Ameri Black, White, Specify: Bla	etc.	
215-0	n 72 hou t. an "natu Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)	b. Kind of Business la					
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Maryland 21215-0036	d be filed Jental Hy irked oth	To Be	17. Father's Name (First, Middle, Last) Herbert Brook	s Sr.		18. Mother's Name Vivi	e (First, Middle, Maid an Kenn	den Surname) e:ly	
Mary	d 2 should alth and N 27 is me or trauma		19a. Informant's Name/Relationship (Tyg. Vanessa M/ Broo	ks / Daughter 19b.	Mailing Address (Street 9707 Ceda	and Number or Rura r Crest	Nay, Up	y or Town, State, Zip per Mari	boro, MD
Baltimore,	permit. Page 1 am Department of He Important: If item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	Disposition (Name of crematory or other place) Journey Cre	ce) !	1	c. Location - City or I	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service License	Porota Marshall	22. Name and Addre Mary I PO_Bo	ss of Eacility and Crem x 1413,	nation So Baltimo	ervices re, MD 2	1203
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		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						
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Box 6876	Attending Physician: The law requires that the death certificate is a death. ard death. ector. After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Sc. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of deli Month	very Day Year
P.O.	that the ned by detac	by Ph	Part II. Other significant conditions con	ntributing to death but not resulting in	the underlying cause gi	ven in Part I.	23e. Did tobac	co use contribute to	the cause of death?
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Recor	sician: The law re s certificate has be lirector, page 2 sh	Completed					24a. Was an autopsy performed	prior to c	opsy findings available ompletion of cause of
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5	hysic this ce al dire	유	1 ☐ Yes 2 🙀 No	lospital:		4 X Nursing Ho		e 6 🗌 Other (Specia	(y)
on of	ending P eath. or: After t he funera	Certificate:	27. Manner of Death 1 🔀 Natural 5 🗌 Pending 2 🗋 Accident Investigation		jury work	y at ⟨? Yes 2 □ No	28d. Describe how i	njury occurred	
Division of Vital Records, P.O.	tal or Attures after de al Directo ed in by t		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	m, street, factory, office		28f. Location (Stree City or Town, S	t and Number or Rura tate)	al Route Number,
	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Examin	ician: To the best of my knowledge, d her: On the basis of examination and/or Practioner: To the best of my knowle	investigation, in my opini-	on, death occurred at	the time, date and p	lace, and due to the ca	ause(s) and manner stated.
	Vith Voith Com		29b. Signature and title of certifier) better	29c. Licens	e number 23743		Date signed (Month,	
1,	10		30. Name and address of person who co Martin Weltz,	MD, 7525 Gree	nway Ct,	Greenbel	Lt, MI) 2	0770	
Ä	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Signature	parke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Medical 12 **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Raven Security Number 3 3 last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗚 2 🗆 F 57 Months Hours Min. 04729/ **Director** MD Usual Residence of Decedent 28a-f show 10a. State 10b. County Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Pasadena MD Anne Arundel 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 493 Riverside Drive 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced 1974 Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with n and Mental Hygien 7 is marked other th 12 Painter Commercial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph R. Booth Sr. Virginia permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type Kimberly Baker / Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 493 Riverside Drive, Pasadena, MD 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🎦 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/15/2011 Woodbine, MD 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation
PO Box 1413, Baltis Services 21<u>203</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, schock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 as use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter for u in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav Year signed by the a d be detached f 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director name? should ha Records, 1 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed Yes 2 1 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 🗹 No ဂ္ 1 🔲 Yes 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis or examination and one investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AXI State

DHMH 17 Rev 7/2009

Registrar

1044 S.

Lah 31. Date filed (Month, Day, Year)

JUN 1 4 2011

m.D. 3900

32. Registrar's Signature

Loca Raven Boulevard, Baltimore, Muryland 2-1218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Elaina Bushey **Physician** 4.00 AM JUNE 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A The Johns Hopkins Hospital Baltimore City 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days June 112 Year 2011 1 🗆 M 2 🔀 F N/A 21 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 Tes 2 X No Maryland Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 1516 Cottage Lane 21286 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary (0-12) College (1-4 or 5+) N/A None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ and 2 should be lealth and Mental William Bushey Jenni fer Storaska ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 William Bushey/Father 1516 Cottage Lane Towson, Maryland Health tem 27 i permit. Pages 1 and Department of Health Important: If item 27 any injury or other tonce. or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corporation 6/13/2011 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Road Towson, Maryland 21204 21. Signature of Funeral Solvice License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Velo Sundrome **Physician** -CATDIO tacial disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last gned by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. eral unrector: After this certificate has been signed filled in by the funeral director, page 2 should be de þ of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home Hospital: Inpatient a No 2 ER/Outpatient 3 DOA 1 Yes 5 Residence 6 Other (Specify) မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Division I or Attending I after death. within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ACUEH MODUPE 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item, 18 per inf g918 8-8-11 yt State of Maryland? Department of Health and Mental Hygiene . . . 1 - For State Registrar Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Christina K. Cameron 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** HOSPITAC TIMORS AGNES 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Jan 28, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Min Days Hours Months Maryland 1 □ M 2 🔀 F 218-05-0693 Director 94 Usual Residence of Decedent 10d. Inside City Limits 10h Counts 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any highty or other traumatic event, the "Natical Event in 15 unit by 1000 and 1000. 1 ☐ Yes 2 No Director Catonsville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 418 S. Rolling Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Christina Marie Schuamann Schuman Andrew J. Groszer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 424 Shady Nook Avenue; Catonsville, MD 21228 19a. Informant's Name/Relationship (Type. Print) Bruce Cameron -Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/14/2011 Big Pool, MD Shanktown Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySterling Ashton Schwab Witzke 21. Signature of Fundal Service License Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, Part : Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neemouia Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part i. ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should i Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerformed's 2. No 1 ☐Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

Reference of the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in by the filled in 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and little of dertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cles as a large of least of the control o 31. Date filed (Month; Day, State parke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death June 8 Pay Physician/ 2011 7:40 Рм Bobby Lee Carmichael, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crownsville Fairfield Nursing Center If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth Age (In yrs. last birthday) **Funeral** Days May 4, 1937 1 X M 2 □ F Hours Min. West Virginia Director 74 235-56-64<u>99</u> Usual Residence of Decedent 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No Crownsville Anne Arundel Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21032 1454 Fairfield Loop 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗌 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2X No Specify: White 3 Divorced Year or Dates 1959-1961 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thai any injury or other traumatic event, the N Transportation Cab Driver 10 Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 9 Aretta Jones Luther William Carmichael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6391 Rowanberry Dr. #402 Elkridge, MD 21075 Ruth Carmichael / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 6/16/2011 Woodbine, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Reverly L. Heckrotte, P.A. Clarksville, M ▶ MD 21029 MO1251 Beverly L. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause yeach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a constitution ce of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the bunal-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe certificate has death? page Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one examiner?

1 Yes 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month, Day, Year) 38958 13 2011

State Registrar Crain

Burnie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

208

trar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 June 11:16 AM Kay Simms Clark Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** 1 □ M 2 🛛 F $V^{(ear)}$, 1952 Washington, DC sept 27, **Director** 215-62-6406 58 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral within 72 hours after death with United States 1908 Rosemary Hills Drive #1 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7's Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Computer Technician Repair 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ruth Rodgers Wilson Howard Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Hills Dr. #2 Silver Spring, MD 20910 Deneen Clark / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 6/15/2011 Woodbine, Maryland 21. Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiac Arrythmia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Acute Respitory Failure Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a consectuence of Exami been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Pneumonia that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 2 X No 1 ☐ Yes 2 ₽ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 M Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🕅 No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural 1 Yes 2 No Accident Investigation after death 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital 24 hours a Funeral L completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

the within To the 29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 1 4 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

arke

1500

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Forest glen, Silver Spring, MD

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death George Edward Colley Jr. Physician/ 12^{ay} June 2011 11:30A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Dundalk4c. County of Death
Baltimore Examiner 8215 Peach Orchard Rd. If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 52 Yrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) MD Funeral 217-62-6229 1 XM 2 🗆 F Months Days Hours 06/19/1958 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Dundalk MD Baltimore 1X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8215 Peach Orchard Road 21222 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HVAC Technician Construction 12 Be 17. Father's Name (First, Middle, Last)
George Edward Colley Sr. 18. Mother's Name (First, Middle, Maiden Surname)

Mary Quinn ൧ 19a. Informant's Name/Relationship (Type, Print)
Sara Ann Colley / Spouse 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8215 Peach Orchard Road, Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Final Journey Crem 1 Burial 2 X Cremation 3 Removal from State 6/15/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service License Dorota Marshal Name and Address of Facility
Maryland Cremation Services
PO Box 143, Baltimore,MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Due to or as a consequence of) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filied in by the funeral director, page 2 should be detached for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) 4 Pregnant a Month Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 2 No 1 Tes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. înjury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

JUN 14

Registrar's Signat

dall.

			Please	Type or Print in				_	•	·.	
			For State	State of Marylan		artment of I tificate of I			2011	10727	
			Registrar 1. Decedent's Name (First, Middle, Las	st)	Cei	uncate or i	Jean	2. Date of Dea	Reg. No	3. Time of Death	
	Physicia Medic			Jean H	Ielen	Cox		June 1	0, Day 2011 Year	8:50 PM	
	Examir		4a. Facility Name (if not institution, give Calvert Hosp	street and number)		4b. City, Town, o	r Location of Death Freder	lck	4c. County of Dea Calve	th.	
	Funeral Director		5. Social Security Number 219-36-8554 6. S	rthplace (State or Foreign ountry) MA							
	or Jow	_	Usual Residence of Decedent 10a. State 10b. County	10c City	y, Town or Lo	cation		(Month, Day 05/10/		10d. Inside City Limits	
	e Marylar r 28a-f sl notified	Funeral Director	MD Calve				Dowe]			1 🄀 Yes 2 □ No	
	th with the ns 23a or must be	neral	10e. Street and Number 975 Appel La			10f. Zip Code 2062			10g. Citizen of What C		
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Ď	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	11	Vas Decedent of H f Yes, specify Cuba □ Yes 2 🛣 No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.	
15-(72 hoi n "nat Aedica	Be Completed	15. Decedent's E (Specify only highest gra	ade completed)	Give I	lent's Usual Occup kind of work done (O NOT use retired)	during most of wor	king	16b. Kind of Business	Industry	
212	within giene. er tha	S	Elementary/Seconday (0-12)	College (1-4 or 5+)	iiie. Do	<u> Illust</u>			Federal (Government	
land	be filed fental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last) Earl Raven	al Bishop					Maiden Surname) n T. Higo		
Maryland 21215-0036	12 should alth and M 27 is ma r trauma:	Ì	19a. Informant's Name/Relationship (7)	ype, Print) Self	19b. Mailin 97 5	g Address (Street Appel I	and Number or Ru Lane, Do	ral Route Number,	; City or Town, State, Z MD 20629	ip Code)	
Baltimore,	age 1 and ent of Hea nt: If item y or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	lace of Disposemetery, cremal Jou	sition (Name of natory or other plac rney Crei	ce) 6/14	Date /2011	20c. Location - City of Woodbine,		
Baltii	permit. F Departm Importa any injur		21. Signature of Funeral Service Licens	,,	11 22	. Name and Addre Marylan	ss of Facility ad Crema	tion Se	ervices		
			23a. Part 1. Enter the disease, or comp	olications that caused the death		PO Box or the mode of dyin	1413, Fig, such as cardiac	or respiratory arre	re, MD 21 est,	Approximate	
	Physician/	2	shock, or heart failure. List only o Immediate Cause (Final disease or condition	Metast Metast	atic	mal	ignant	mela	noma	Interval Between Onset and Death	
	Medical Examiner		resulting in death)	a. Due to (or as a consequ			1			D qears	
		je	Sequentially list conditions,	Due to (or as a consequ	lence off:						
	rted d unsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury								
	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as a consequ	ence of):						
9	ate be hysici the bu	dical		d							
687	eath certificate b attending physic for use as the b	₩ We	F FEMALE:	23c. If yes, outcome of pregnar	ncv				1		
Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2☑ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnand Other (specify)	у		Month	late of delivery Ionth Day Year	
P.O.	that the	by Ph	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did tol	bacco use contribute to	o the cause of death?	
ds,	quires ten signal	ed b						1 □ Y	′es 2X No 3□ F	Probably 4 🗌 Unknown	
cor	aw rec as bee 2 sho	Completed						24a. Was a		topsy findings available completion of cause of	
Re	The la	5						perfor	med? death?	s 2 🗆 No	
ital	sician certifi rector	œ /	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ X lo	Hospital:		Oth	ace of Death (Chec			II a mad ma	
of V	y Physer this eral di	<u>မ</u>	27. Manner of Death	1 Inpatient 2 Inpatient 2 28a. Date of injury	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injun	4 ☐ Nursing H		ence 6 🛛 Other (Spec ow injury occurred	cify)Hospice	
on	ending sath. or; Afte	licat	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation		injury	M 1 🗆	? Yes 2 🗆 No				
Division of Vital Records,	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hou building, etc. (Specify)	me, farm, stre	et, factory, office		28f. Location (St City or Town	Street and Number or Rural Route Number, vn, State)		
Ω	Hospital 4 hours Funeral ted filled	ल्	29a. Certifier 1 Certifying Phys	sician: To the best of my knowle ner: On the basis of examination	edge, death o	ccured at the time	, date and place, a	nd due to the causet the time, date an	se(s) and manner as st	ated.	
	o the lithin 2 or the comple		only one) 3 Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the best of my	knowledge, d	eath occurred at the	e time, date and pla	ce, and due to the	cause(s) and manner as	stated.	
	⊢≶⊨ő			Bennett 10		1	25156		June 13,		
l	3 √		30. Name and address of person who c Charles Bennet	ompleted cause of death (Item	23a) (Type, Pr 45 H.	G. True	man Roa	d, Lusk	oy, MD 20	657	
	Stat Registra	-	B1. Date filed (Month, Day, Year)	32. Registrar's Signatu	fact.	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 35A M ACK 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GENERA If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕱 F Months Days Hours March 28,1930 Maryland 218-28-6330 Director 81 Usual Residence of Decedent show 10a. State 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 K No MD Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 3004 North Ridge Road 21043 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 X Widowed 4 Divorced White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frank Denoe Gladys Waltmeyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i Ocean City, Maryland 21842 12 52nd Street Barbara L. Carr (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o Meantowridge Memorial Park þ 1 X Burial 2 Cremation 3 Removal from State 6-9-2011 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 21. Signature of Funeral Servic 22. Name and Address of Facility Witzke Funeral Homes, MU1283 5555 Twin Knolls Road Columbia, MD Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by THROMCYTORENIC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Hnpatient 2 -ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEDAR LANGICOLUMBIA, MY ANUMURU

DHMH 17 Rev 7/2009

State

Registrar

filed (Month, Day,

1 4 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June Cottrell 2011 Julian 11:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Sandy Spring Friends Nursing & Rehab. Center If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. 1**XX**M 2 □ Months Days Hours (Month, Day, Year Virginia 87 Ĩ′923 Director 578-38-3663 shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 273 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Director Silver Spring 1 ☐ Yes 2 X No MD Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 20906 14611 Layhill Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1XXYes 2 □ No If Yes, Give W W 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. If Yes, Give Year or Dates. W. W. II 3 Divorced White Completed Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 12 Microwave Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Cottrell Evelyn Julian Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14611 Layhill Rd., Silver Spring, MD Derrelie Cottrell / Wife Department of Healt Important: If item 2 any injury or other once. 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory | 06/14/2011 Beltsville, MD Signature of Funeral Service Licensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD m00382 Stisling Lohn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RESPIRATORY FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CEREBRAL VASCULAR DISEASE Sequentially list conditions, if any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury Due to for as a poncedulance of CEREBRAL VASCULAR ACCIDENT Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes XXNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 1 Ves 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director Other: 4XXNursing Home 5 - Residence 6 - Other (Specify) ျ 1 Yes XX No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After 1 🕅 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. e Funeral Director: A bleted filled in by the fu Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [within 2

To the I

complet only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 13, 2011 D35791 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Merlyn Vemury MD, #227, SILVER SPRING, MD 20902 9801 GEORGIA AVE.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DATRI Month Vear VERONICA Physician/ June 12:28 AM 09 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Haspital Harbor Baltimore 8. Date of Birth g. (Month, Day, Year) April 6,1963 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number last birthday) **Funeral** Days Philippines 1 □ M 2**X**□ F 48 Months Hours Director 149-72-6489 show 10d. Inside City Limits 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County be filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔀 No Kendall Park NJMiddlesex 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? United States Funeral 08824 36 Stanford Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 Filipino 1 ☐ Yes 2X No Specify: "natural", 3 Widowed 4 Divorced Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Adoracion Santiangco Jorge Ongsiaco and 2 should be Health and Metern 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36 Stanford Drive, Kendall Park, NJ08824 James A. Datri, Husband Baltimore, 20b. Place of Disposition (Name of cermetery, crematory or other place)
Holy Cross Burial 06/13/201 East Brunswick, NJ 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility M.J. Murphy Funeral Home 21. Signature of Funeral Service Licensee 616 Ridge Rd, Monmouth Junction, NJ 08852 Durray 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Mileoid Acute disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Mylodysplasia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying 24 hour Indrome lysis Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) the a g Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed Yes 2 1 Yes 2 No Be 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No funeral director. 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; A Investigation Accident the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29d. Date signed (Month, Day, Year)
June, 09, 2011 29b. Signature and title of certifier RES 001 SW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harbor Hospital, 3001 South Harover Street, Baltimore, Mayland, Dr. Mahalis Sangh 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ William OZY5 M 2011 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Howard Hosp. be1 Howard County Colonbia Gerend If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Min Maryland 219 38 4222 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State Director MD 1 Yes 2 X No Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21043 3934 College Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Insurance Underwriter Insurance Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည William Roger Davis Margaret Hess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Wife 3934 College Avenue; Ellicott City, MD 21043 Sally Davis 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)

Lorraine Park Cem. 1 X Burial 2 Cremation 3 Removal from State 6/20/2011 Woodlawn, Maryland 4 Donation 5 Other (Specify) Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service Licensee 'uneral Home of Catonsville, Inc. 630 Edmondson Avenue; Catonsville J2010x 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stroke Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Chronic Kid Sequentially list conditions. Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Peripheral Varcillar 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has to the Funeral Director. After this certificate has to the Funeral director, page 2 s autopsy 2 **X**No Yes 1 Tyes 26. Place of Death (Check only one) Be B 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA 욘 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural 5 Pending ☐ Accident ☐ Suicide ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Medical Examiner: On the basis or examination and on investigation, in my opinion, seat to consider the cause (s) and manner as stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 11, 2011 D52817 Mark Course MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Corrière 5755 Code , lane, columbia 31. Date filed *(Month, Day, Year)* **JUN 1 4 2011** State arks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 201^{Yea}_{1} Emilie F. Daly June 13 1:15 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Charlestown Dorsey Center Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Hours Director 044-09-3731 90 May Connecticut Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified MD Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 715 Maiden Choice Lane PV214 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own_Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph J. Fitzpatrick Emilie Reichenbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edmund J. Daly IV- Son 118 Fairfield Drive; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Mt. Olivet Cemetery 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Watertown, CT 6/27/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 *i*/40(057) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death h sician/ umone disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e.
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: Nursing Home 5 - Residence 6 - Other (Specify) မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 \sum Yes 2 \sum No Investigation Accident completed filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title o

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

cause of death (Item 23a)

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11:25 PM **Physician** del Puso 09 2011 Norma /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Agnes Hosni tal Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 🔀 F N/A Feb 13, 1948 Philippines Director 63 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examination is at the Infilial and once. 1 ☐ Yes 21 No Director Baltimore Gwynn Oak MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Philippines 21207 1813 Gwynn Oak Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1∐Yes 2∭Wo Specify: Asian Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Child Daycare 12 Caregiver 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nasaria Arnaldo Jaime Daquiso ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1813 Gwynn Oak Ave. Baltimore, MD 21207 Leoncio del Puso, Jr./Husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Final Journey Crematory 06/14/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li Sing Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pontine **Physician** Itonte disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 □Yes 2 □No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann Death 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year)

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 1 4 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900

32. Registrar's Signature

29c. License numbe 25412

tvenue

Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jun Nonth Physician/ Zoil 0740 M Ed Peter Dunning, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Jentor 544 Retreat Court Apt. D If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Months Hours 02-24-1949 South Carolina Director 62 Yrs. 247-82-7221 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 XNo MD Anne Arundel 0denton 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be 23a Funeral 544 Retreat Court Apt. D 21113 United States items and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 X Yes 2 No Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural" Specify: Completed 3 Widowed 4 Divorced **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Marshal Service event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Ed Peter Dunning, Sr. Wilhelmenia Haynes traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Patricia Dunning / Wife 544 Retreat Court Apt. D Odenton, Maryland 21113 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Veterans Cemetery! 06-15-2011 | Crownsville, Maryland Funeral Survice D Name and Address of Facility Donaldson Funeral Home & Crematory, P.A Annapolis Road Odenton, Maryland 21113 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Arterios Immediate Cause (Final Onset and Death Ph_sician/ 15CAS disease or condition Medical resulting in death) **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 res, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed Yes 2 1 Tes 2 🗌 No 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Deputy D06054 of JUN 1 4 2011 State Registrar

11-04414 Russell Joseph D	Dunr	Please Type or Print in Black Indelible Ink. Ensure All Cop State of Maryland / Department of Health and Mental I	ies Are Leg Ivaiene	ible.	18735
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Funeral	Т	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		(MM/DD/YYYY) 9. Bir	
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any	F	Usual Residence of Decedent 10c. City, Town or Location			10d. Inside City Limits
*		MD CARROLL SYKESVILLE			1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at noce.	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	ntry?
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t be ng	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puel	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", ar items 23a or 28a-f sha injury or other traumatic event, the Medical Examiner must be notified at nace	Be C	17. Father's Name (First, Middle, Last) BENNANO OUN ELV	_	ALEY	
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Baltimo permit. Page Department o Important: J		4 Donation 5 Other Specify: OUTH CARROUGHEM 6, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	114/2011	WINFIELD WEH &	O, MO
Bal permi Depar Impo		Jehn W. Zumbrum 16025 SYEES VILLE	NEUMSI	WERSBURG	MOD 21784
Physician	1	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiar	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
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	<u>ē</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
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Division of Vital Records, P.O. is a rattending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the fameral director, page 2 should be detach		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
Sion kttendi death. ctor: y the f	äţie	2 Accident Investigation	29f Location (C	troot and Number of Pr	ural Route Number, City
Divis al nr A	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, St		draf Route Humber, Only
Division of Vital Records, P.O. Box 68760, To the Hospital no Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		4 Homicide 29. Entire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cause	e(s) and manner as sta	ed.
o the lathin 2 o the lambda	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	d at the time, date a	and place, and due to th	ne cause(s)
F 3 F 8	Z.	29b. Signature and title of certifier 29c. License number	•	29d, Date signed (Mo	nth, Day, Year)
		MAY CO.C.M.E.		June 13, 2011	
	Į.	30 Name and address of person who completed sause of death (Item 23a)			

State 31, Date filed (Month, Day, Year)
Registrar JUN 1 4 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ruby Deem 10 p Jun-201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Season's Hospice Randallstown Baltimore If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 4 2 4 - 4 6 - 5 1 5 5 Birthpiac Country) AL . Age (In vrs. last birthday) **Funeral** Days 06/30/1939 1 □ M 2 🛣 F 71 **Director** Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Crane Hill Cullman 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 35053 USA 507 Country Road 359 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married Yes Yes, Give 2 **X**No Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last)
William McCoy 18. Mother's Name (First, Middle, Maiden Surname) NeTTie PoweTT ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 Country Road 359, Crane Hill, AL Charles F. Deem Jr/Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State rinal Journey Crem. 1 Burial 2 Termation 3 Removal from State 6/9/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ cancer ovarian disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Day 5 Other (specify) Pregnant at time of death detached 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by should be 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Vatural 5 Pending 1 🗌 Yes 2 🗌 No within 24 hours after death

To the Funeral Director: A
completed filled in by the f 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier WajapahseM. K ٥ 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N S RAAPA LSE (M D 2535 S m M M ... Baltimore S- 203 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2011

Registrar

11-04347 Peggy Decker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death Reg. No.												
Physician	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year									ar	3. Time of Death		
Medical Examine	Peggy Decker June 9, 2011									111		1747 hrs	
	1	4a. Facility Name (if not instited 8145 Cyprus Ceda		street and nu	mber)		b. City, Town, o Ellicott	or Location (of Death		4c. County of Howard	of Death	
Funeral		5. Social Security Number	6. Se:	(7. Age (In yrs. I	last birthday)	If Under 1 Ye			8. Date of Birt	th(MM/DD/YYYY	Foreig	n
Director	ı	212-54-9218	1	M 2XXF	59	Yrs.	Yrs. Months Days Hours Min. 04-01-1952						untry) MD
b	_	Usual Residence of Deceder 10a. State 10b. Cou			Ino City	, Town or Locati	20						10d. Inside City Limits
ow any		MD TOD. Cou	•		Toc. City	, TOWITOI LOCALI	JII	D11.		0			1 Yes 2 X No
yland	ĘĻ	10e. Street and Number	Howa	ru			10f. Zip Code	LT11	cott		Og. Citizen of Wh	nat Cour	
Baltimore, MD 21215-0036 semit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show niury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Exinged Disperse		8145 Cyprus (odor	Lano	Ant D			21043		'`			•
with t		11. Marital Status	euai		edent Ever in U		Decedent of H	lispanic Orig			United 14. Race		can Indian, Black,
r death with or items 23	}	1 Never Married 2	Married	Armed Fo	rces?	If Yo	es, specify Cuba	an, Mexican	, Puerto Ri	can, etc.)	White	e, etc.	
s after oral", o				If Yes, Give Year or Dates:	r	1 Yes 2 X No specify:					Specify:	Whi	te
hours Fram	3	15. Decedent's Education ('s Usual Occup				16b. Kind of Bu	siness/I	ndustry
5-0036 ed within 72 hour fygiene. other than "natu the Medical Exam		Elementary/Secondary (0-	12)	College (1	-4 or 5+)		N					1 1	т 1
I with	<u></u>	17. Father's Name (First, Mid	dle, Last)				Nurse	18.Mother	's Name (F	irst, Middle, M	Speci		leeds
215 be file and Hy rked o		Thurmon Jo		Gauldi	.n			Margaret			Hind		
MD 21215-0036 at 2 should be filed within 7 th and Mental Hygiens a 27 is marked other than rumatic event, the Medical TO Be Comple	2 [⁻	19a. Informant's Name/Relati							nber or Rur	ral Route Num			Zip Code)21043
MD d 2 sh lith an b 27 i		Cecil Decker	- sp	ouse							Ellicot		
s lan filter frier frier frier frier		20a. Method of Disposition 1 X Burial 2 Crema	tion 3	Removal fro		Place of Disposi crematory or oth		emetery,	,	Date	20c. Location -	City or	Town, State
Page nent of out		4 Donation 5 Othe	Specify:			adowridg	e Mem F	ark	06-13	3-2011	Elkrid	ge,	Maryland
Baltimore, Peemir. Pages I a Department of He Important: If ite Important: If ite Important or other to	- [21. Signature of Funeral Sen	ice Licens	7	$\overline{}$	22. N	ame and Addre	ss of Facility	y Gary	/ L. Ka	ufman F	uner	al Home at
	4	23a. Part I. Enter the disease	SAC.	rains that as	used the death								MD 21075 Approximate Interval
Physician /Medical	1	failure. List only one ca	use on eac	h line.				71	ardiac or re	espiratory arre	st, shock, of hea	art	Between Onset and Death
Examiner		Immediate Cause (Final dise or condition resulting in deat			consequence of	lerotic Cardi	vascular D	isease					Death
	1	Sequentially list conditions,	b.			.,,.							
, de		if any, leading to immediate cause. Enter Underlying Cau		Oue to (or as a	consequence o	of):							
red Insit		(Disease or injury that initiate events resulting in death) La	d ^{C.} -	Due to (or as a	consequence o	of):							
executed an and all - transit	<u> </u>		d										
- 0) :5:5	3	UNPENDED		AMENDED									
760, ficate be g physici the buri	E 2	F FEMALE: 3b, Was decedent pregnant	n the		outcome of preg						23d. Date of		
c 68 certif ending use as		past 12 months?			irth ant at time of de	anth	al death 3 er (Specify)	Ectopio	c pregnanc	У	Month	D	ay Year
b. Box 68 the death certification of the attending ched for use as Dhyelcian	2	1 Yes 2 No 9 ✓	Unknown	9 Unkno	wn	о <u>г</u> 0	ei (opean))						
Vital Records, P.O. Box 68' sysician: The law requires that the death certifian his certificate has been signed by the attending director, page 2 should be detached for use as the Recompleted by Dhustrian		Part II. Other significant con	ditions	contributing to	death but not r	resulting in the u	nderlying cause	given in Pa	art I.				he cause of death?
S, P uires ti n signo d be d													ably 4 🗹 Unknown
Ord w req as bee shoul										24a. Was a autops	sy p	nior to co	opsy findings available ompletion of cause of
Records, The law require. ficate has been signage 2 should be	ξ									1 Yes 2		leath?	s 2 No
cian: certifi ector,		25. Was case referred to med examiner?		itali			26.Plac	ce of Death					
of Viling Physics After this funeral directory	١	1 Yes 2 No			npatient 2	ER/Outpatient		Other ₄	Nursing I		Residence 6		Scene
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Sion Atten r deat ector by the	5	2 Accident	vestigatio	28a Place	of Injury - At h	nome, farm, stree				Rf Location (S	treet and Number	er or Rur	al Route Number, City
Division of Vital Records, spital or Attending Physician: The law requiremental birector: After this certificate has been sfilled in by the funeral director, page 2 should I Certification: To Be Commister			ould not be etermined	e	or injury - 74 m	iomo, iam, ou co	i, lactory, omoc	building, et		or Town, St		51 01 1(4)	arroate Nambor, Oity
27. Manner of Death 1								e(s) and manner	as state	d.			
													cause(s)
T NE S		29b. Signature and title of ce	tifier		1		2.2	ise number	•		29d. Date signe		th, Day, Year)
		Call	1	1 1	1		0.0	.M.E.			June 10, 20)11	
Su	1	80. Name and address of per								D 04		_	
		Zabiullah Ali, M.D.				900 W. B	aitimore Str	eet, Balti	more, M	21223 טו			
Stat Registra	_	31. Date filed (Month, Day, Ye 10011	dr) h	32. Re	gistrar's Signati	Mal							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #2 Per PHY G916 6/14/2011 JH
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death **Jun. 10, 2011** 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 15:38 PM JAMES DANIELS III Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A HOSPITAI BALTIMORE MD G000 SAMARITAN Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day Year 9-6-1948 Days 1 XM 2 □ F Hours Min. MARYLAND **Director** 215-52-4702 62 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 ₹ Yes 2 ☐ No MD. N/A BALTIMORE 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 1926 E. 28th ST. 21218 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examirance. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DRIVER -12-TRANSPORTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JAMES DANIELS II LUCILLE CHAMBERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8362 CHURCH LANE BALTIMORE, MARYLAND 21244 CHARLOTTE DANIELS (WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial Z X Cremation 3 ☐ Removal from State METRO CREMATORY 6-14-2011 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. Signatur of Frieral Service Licensee JONATHAN. D. HIBNER2. Name and Address of FacilityPHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death or heart failure. List only one cause on each line. Immediate Immediate Cause (Final disease or condition Physician RESPIRATORY FAILURE HOURS Medical resulting in death) Due to (or as a consequence of): Examiner DA45 SEVERE PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Dus to (or as a consequence of): YEARS Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi END STAGE LOPD SEVERE attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown COPD, PVD (PERIPHERAL VASCULAR DISEASE), Completed peen 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an LUNG NODULE (NEGATIVE PET SCAN) has autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No 2 Accident 3 Suicide Investigation after death Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the des 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 06/10/2011 M.D. RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SRITIKA THAPA M.D. BALTIMORE

DHMH 17 Rev 7/2009

State

Registrar

Year) 4 2011

ama

parke

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 0 2011 09 58 Tune 08 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Manor Care | Honder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug 30, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 X F 1916 94 Director 217-22-5047 Usual Residence of Decedent la or 28a-f show t be notified at 10a, State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 ₹No Directo MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a (Medical Examiner must b USA 21234 1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene em 27 Is marked pither than 1 2800 Upridge Court by Funeral Apt. E 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify. Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be me...
h and Mental Hygiene.
...7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 10 Clerk Electronic Parts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ella Neunsinger Lawrence Murnaghan ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14215 Quail Creek Way #308; Sparks, MD 21152 Dr. Paul J. Edgar son permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other: Pages 1 iment of Hr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp 6/10/2011 Towson, MD 21. Signature of Funeral Service 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) ment /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Box 687607 Due to (or as a consequence of) Physician/Medical IE EEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) P.0. 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performe certificate 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) al or Attending Physic s after death. 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending (Month, Day Year) investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 of death (Item 23a) (Type, Print) Name and address Bellona Lame #216, Towson MD 2120 0

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month; Day,

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2011 9:25 A M Harry L. Freeman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Chevy Chase 4708 Dorset Avenue If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 8. Date of Birth Social Security Number **Funeral** Months Days Min (Month Day, Year) 32 1**X** M 2 □ F Hours Nebraska Director Mar 79 <u>506-34-7469</u> Usual Residence of Deceder items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 Yes 2 No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20815 4708 Dorset Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter edical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Yes 2 XNo Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Financial Corporate Executive Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Celia Gidinsky Joseph Henry Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4708 Dorset Ave Chevy Chase, Lucile C. Freeman / Wife MD 20815 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Journey Crematory 6/15/2011 Woodbine, Maryland 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Signatore of Funeral Service Lice MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_ician/ days disease or condition a. Pneumonia Medical resulting in death) Due to (or as a consequence of): **Examiner** b. Multi System Atrophy 10 years Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or iinjury that initiated events resulting in death). Let Exami burial-transit and Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Por Pregnant at time of death 5 Other (specify) Month Day Year ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed ! 23e. Did tobacco use contribute to the cause of death? þ Records, Non-Insulin Dependent Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed? Yes 2 K No 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tyes 2 🔀 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 24 hours after death.
Funeral Director; After the eted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 X Natural 5 Pending work 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Etrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certif Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 stifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D50030 June 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 5530 Wisconsin Ave Ste. 1400 Chevy Chase, MD 20815 David Rogers, 31. Date filed (Month, Day, 32. Registrar's Signature State JUN 1 4 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Macfarlane June 12^{Day} Feininger Marilyn 2011 6:40 A M . Medical 4a. Facility Name (if not institution, give street and number) 9707 Old Georgetown Rd. #2305 Maplewood Park Place 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Bethesda 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day 1 □ M 2 XX Months Days Hours Country) New York 79 1931 032-24-5637 Director Aug. Usual Residence of Decedent show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director notified Bethesda Montgomery 28a-f MD 1 Yes 2XXNo 10e Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 9707 Old Georgetown Rd. #2305 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2XXNo Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes XX No Specify: If Yes, Give Year or Dates Specify: White "natural", 3X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Volunteer Community Service alth and Mental Hygier
27 is marked other to traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Macfarlane, Jr. Elizabeth Chase Kerr Kilgore Walter Page 1 and 2 should I ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2612 Shoreland Dr. S, Seattle, WA Anne Mulherkar / Daughter Department of Health Important: If item 27 any injury or other the 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Chesapeake Crematory 1 Burial 2 XCremation 3 Removal from State 06/14/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ BREAST CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or impury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): physician s the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 nding p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten in the past 12 months?
1 Yes 2 X No Month Dav Year Pregnant at time of death the a ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires ATRIAL FIBRILLATION 1 Yes XX No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed page 2 certificate 2 \square No 1 Vas Yes 2V VN 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ሺ No 1 Inpatient 2 ER/Outpatient 3 DOA ျ this After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1XXNatural work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours arter community to the Funeral Director: Aftr ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D55258 June 13, 2011 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V OR GARY B. WILKS M.D., 7858 WISCONSIN AVE. #211, BETHESDA, MD 20814

Registrar

State

31. Date filed (Month, Day, Year)

JUN

14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 Per FH G916 6/16/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 10^{ay} 2011 11:40 AM Pascal Girard June Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Somerford Place Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) **Funeral** Months Days Hours 1 XM 2 🗆 F (Month, Day, Year) 04-20-1935 76 FRANCE 216-34-2892 Yrs **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director 1 🗌 Yes 💥 No Pikesville Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Numbe Funeral 21208 items 23a 1400 Woodholme Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Black, White, etc. 6 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Vice-President other traumatic event, Be permit. Page 1 and 2 should be file.
Department of Heath and Mental H
Important if item 27 is marked off
any injury or other formation. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Agnes DeLouis Joseph A. Girard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005 Radley Drive, West Chester, PA 19382 Armand Girard- SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial X Cremation 3 Removal from State cemetery, crematory or other place) 06-11-2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory INC gnature of Funeral Service Licensee Patrik Fleming 22. Name and Address of Facility Cremation Society Of Maryland MD 21228 INC 299 Frederick Road, Balto, 23a. Part 1. Enter the disease, or complications that cause of e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between DEMENTTA Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or imjury that initiated events Examine Due to (or as a consequence of) burial-transit that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown DEBILITY Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? Other: 2 1 No 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manne Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at (Month, Day, Year) Natural 5 Pending worl s after death.

I Director: Af 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. 056531 June 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li 8600 Snowden River Parkway #301 Columbia, MD 21045 Date filed (Month, Day, State JUN 1 4 2011 parke Registrar

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5	/		30. Name and address of person who	ompleted cause of d	eath (Item	23a) (Type, F		noth -	L = 1		Man	~ 1 mg /c .
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	Funeral		5. Social Security Number 6			nst birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da			thplace (State c	or Foreign
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	yland f shov ed at	tor	10a. State 10b. County 10c. City, Town or Location									10d. Inside Ci	ity Limits
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	death r items ner m		11. Marital Status	12. Was Decedent E Armed Forces?		3. 13. \	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Ame Black, White	rican Indian, e, etc.	
036	rs after ral", o Exam	ed by	1 ☐ Never Married 2 ☐ Marrie 3 🕱 Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give X Year or Dates.	No		Yes 2 No	Specify:		Spe	ecify: Wh	ite	
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ore	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition 1X Burial 2 Cremation 3	Removal from State	c	emetery, crer	sition (Name of natory or other plac	e) 6-14-	Date			Town, State	
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	To the within To the Comple	Σ	29b. Signature and title of certifier	Nurse Practioner: To the	best of m	y knowledge,	29c. License		ce, and due to ti			h, Day, Year)	
	(.		► XWWW	WOOD	V	Do	H4	1069		June	213	,201	1
	2 8h		30. Name and address of person w	no completed cause of d	eath (Item	23a) (Type, I	10% (1	Wau #	102	Fdm	ewa	1 21	048
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture	/ ()		100			J.	10
	Registr	ar	JUN 1 4 2011	enews G.	ga	Kel							

GARRITY EDWARD

JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. 31. Date filed (Month, Day, Year)

erson who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

roleted 1

29a. Certifier

(Check

29b. Signature and litle of cer

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 I Medical Examiner: On the basis of examination and/or investigation, in woopinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year,

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item# 26 per phy, g916 6-14-11 sm
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ GREENBERG JOSEPH 8:00 A M JUNE 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 3801 CANTERBURY ROAD #506 BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 92 Days Hours Min Months 1 X M 2 □ F 5/19/19^y919 216-01-6714 **Director** MD Usual Residence of Decedent shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland at Directo ams 23a or 28a-f sh r must be notified a MD N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3801 CANTERBURY ROAD #506 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1

Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, iral", or iten 11. Marital Status Black, White, etc. ò permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
SALES 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ ISADORE GREENBERG SARAH KAPLAN 19a. Informant's Name/Relationship (Type, Print)
CHERYL KAMMERMAN/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 POPLAR COURT, OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW 6/12/2011 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ned by the atten detached for u in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 Yes 2 🖸 No 1 Inpatient 2 tpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 🗷 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 2 Accident
3 Suice 5 Pending work 1 \square Yes 2 🗌 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. re and title of certifier 29c. License numbe 29d. Date signed (Manth, Day, Year) 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State 1 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item# 11 per fh, g916 6-21-11 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death June Day 201 Year Physician/ 12, 4:40 A M George W. Heck, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Seasons Hospice 5 Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral XXM 2 D F Months Hours Jan. 18, 1922 Maryland 89 **Director** 165-12-5841 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c City Town or Location **Funeral Director** 1 Yes 2XXo Baltimore Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 6709 Mt. Vernon Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married XXYes 2 ☐ No If Yes, Give Year or Dates. W Maryland 21215-0036 1 Yes 2XXNo Specify Specify: White Completed 3 Widowed 4 X Divorced WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Baltimore Elementary/Seconday (0-12) College (1-4 or 5+) County Schools Principa1 5+permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important; If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٩ Lillian Lena Herrmans George W. Heck, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6709 Mt. Vernon Ave. Baltimore, MD 21215 Personal Rep. Mary Lee Ward Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
All Faiths
-cmatory & Chap 1 Burial 2 X X remation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/14/11 Manchester, MD pel Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature o un ral S price Licens 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Heute Physician/ mocardi 100.03 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner reavs Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) al ent Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify, 2 🗗 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Accident the f Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 To the h only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) 037513 12, 2011 June 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIDEN MO 21209 Jof 2835 D 31. Date filed (Month, Day, Year, 32. Registrar's Signature State JUN 1 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5perFH, G917,7/21/2011, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Month Physician/ Luther Hill Maynard 4:10 A June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 2001 Norvale Road Silver Spring 8. Date of Birth (Month, Day, Year) Feb 21, 1926 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 3564 1 🛛 M 2 🗆 F Months Davs Hours Pennsylvania **Director** 85 Feb 465 or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland Examiner must be notified at Director 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zin Code Funeral "natural", or items 23a 20906 USA 2001 Norvale Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. 11. Marital Status rmed Forces?
Yes 2 \(\square\) No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturon" any injury or other transmin ģ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Year or Dates. 1945-47 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Defense Solutions Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ၉ Esther Berger Claude Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 Norvale Road Silver Spring, MD 20906 Gay Hill/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🛛 Cremation 3 🗆 Removal from State Final Journey Crematory 06/11/11 Woodbine, MD 4 Donation 5 Other (Specify) 21. Sign e of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD Þ MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Prostate disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has formoleted filled in by the funeral director, page 2.8 autopsy performed? Yes 2 X No 1 Yes 2 No 25 Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and this of certifier 29d. Date signed (Month, Day, Year) June 9, 2011 039190 address of person who completed cause of death (Item 23a) (Type, Print) Garrett Reilly, M.D. 3418 Olandwood Ct. #111 Olney, MD 20832 31. Date filed (Month, Day, Year JUN 1 4 201 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death
June 10, 2011 Physician/ Year Jason Christopher Hume 11:55 A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice 7. Age (In yrs. last birthday) 27 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Social Security Number **Funeral** 1 🛛 M 2 🗆 F Months Days Min. (Month, Day, Year) an. 26, 1984 Hours Maryland **Director** 219-04-9783 Jan. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location Abingdon 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Harford 1 ☐ Yes 2🛣 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21009 2907 Brightwater Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) life. DO NOT us Painter Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Residental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dawn Marie Hume မ Charles Leslie Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2907 Brightwater Lane, Abingdon, Maryland 21009 Dawn M. Shaw Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 06/14/2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Funeral Service Licens 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road. Baltimore, Marvland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ Cinhosos disease or condition resulting in death) Herre Medical Due to (or as a consequence of) Examiner alional Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the attending phases the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, hemochromatusis 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 🗌 Yes Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificated filled in by the funeral director, it Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Fother (Specify) Herry if မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 1007065 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) belt nove his ridge 4105 houses of sure Part (0 101 alva 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2011 JUN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Huiling Hu Physician/ Month 5:15 PM Tune Medical 4a. Facility Name (if not institution, give street and number) E. County of Death Baltimore Examiner 4b. City, Town, or Location of Death Gilchrist Hospice Towson 9. Birthplace (State or Foreign Country) China 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days 402-53-3180 1 🗆 M 2 🗔 🛪 49 Months Hours 01715/1962 Yrs Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director Woodstock MD Howard 1X Yes 2 ☐ No 10g. Citizen of What Country? 10e Street and Numbe 5 10f. Zip Code 10483 Petersboro Road 21163 Funeral items 23a 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Asian 1 Yes 2X No Specify. Specific "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) College (1-4 or 5+) 5 + Elementary/Seconday (0-12) 12 Scientist Healthcare traumatic event, Be 18. Mother's Name (First, Middle, Majden Surname)
Duoying Zhang 17. Father's Name (First, Middle, Last) and Mental F .. Page 1 and 2 should be filk tment of Health and Mental tant: If item 27 is marked o ൧ Bozhi Hu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10483 Petersboro Rd., Woodstock, MD Xiaohu Chen / Husband 21163 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State cemetery, crematory or other place)
Final Journey Crem. ō permit. Page Department of Important: If any injury or once, Woodbine, MD 6/13/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensedorota Marshall le U Marsh soul! 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or imjury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year the page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 2 No 1 🗌 Yes Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 6 Other (Specify) WOSPLO Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 27. Manner of Demh the funeral 1 Natural 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury After 5 Pending work s after death. 1 🗌 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 4 Homicide Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 58300 201 we 10 ss of person who completed cause of death (Item 23a) (Type, Print) Name and addr N. Charles M) 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 4 Registrar

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	_ State	State of Maryland	•	tificate of E		wentai Hy	gienę.	2011	18751
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Physician/ Medical	June E. Healy					Month	Day	2011 Year	3. Time of Death 4:36 P M
Examiner	4a. Facility Name (if not institution, give stree	•			Location of Death	1		County of Death	
	Harford Memorial Ho 5. Social Security Number 6. Sex		at hirthday)	Havre If Under 1 Year	de Grace I If Under 24 Hrs.			Harford	
Funeral Director		7. Age (In yrs. la 88	Yrs.	Months Days	Hours Min.	June 10,	y, 192 2	Balt	place (State or Foreign otry) Incre, Maryland
77 0 1	Usual Residence of Decedent 10a, State 10b. County	10.00			· · ·				····
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death litems litems	The state of the s	Was Decedent Ever in U.S Armed Forces?		Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp In, Mexican, Puert	pecify Yes or No- po Rican, etc.)		14. Race - Ameri Black, White,	
Maryland 21215-0036 2 should be filed within 72 hours after of the and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Examir To Be Completed by	1 Never Married 2 Married	1XX es 2 ☐ No If Yes, Give Year or Dates.		☐ Yes 2 No				Specify: Wh	
21215-003 iene. r than "natural" the Medical Ex.	15. Decedent's Educat	tion	16a. Deced	ent's Usual Occup	ation			nd of Business Ir	
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aryl aryl nould ind Me s mar umati	19a. Informant's Name/Relationship (Type, F	Print)	19b. Mailin	g Address (Street a					Code)
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Ore or oth	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem			sition (Name of natory or other plac	e) June	Date 14.		cation - City or T	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	4 ☐ Donation 5 ☐ Other (Specify)	Bal		ational temperature	tery 20	11 '	Balt	timore, Ma	ryland
Baal Baal Department once	21. Signature of Funeral Service Licen ee	X011	22.	Name and Address	ss of Facility gral Chapel ord Road	& Crenat	ian Se	ervices Pa	rkville
	23a. Part 1. Enter the disease, or complicat shock, or hear failure. List only one ca	ions that caused the death	. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory an	est,	ZIBIU ZIZ3	Approximate
Physician/	Immediate Cause (Final disease or condition	duse off each line.	ASI	KATION	/ he	7/11010	14	3	Interval Between Onset and Death
Medical Examiner	resulting in death)	Due to (or as a conseque		WILIUNG	1100	LIM LAY			
Je Je Je Je Je Je Je Je Je Je Je Je Je J	Sequentially list conditions, b	Due to for as a consequ	arine on					- 10	
xecuted n and al-transit Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events								
O s be executed /sician and e burial-transit ical Examii	resulting in death) Last	Due to (or as a consequent	ence of):						
760 cate by	d								
Sox 6876C eath certificate I attending phys of for use as the	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregnar	псу	5-071				23d. Date of deliv	verv
Records, P.O. Box 6876 The law requires that the death certificate tate has been signed by the attending phypage 2 should be detached for use as the Completed by Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live Birth 2 Fetal 4 Pregnant at time of degrees 9 Unknown		Ectopic pregnand Other (specify)	СУ			Month	Day Year
P.O. Be that the degree bed by the good detached by Physic	9 ☐ Unknown Part II. Other significant conditions contrib		ıltina in the uı	nderlying cause giv	ven in Part I	220 Did to	shacoo u	co contributo to t	he cause of death?
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ords, ords, w require s been si should lishould						24a. Was		24b. Were auto	psy findings available
fital Reco sician: The law is certificate has to ligitate has to ligit and the second of the second						autor		prior to co	mpletion of cause of
tal F cian: T	25. Was case referred to medical examiner?			26. Pl	ace of Death (Che		ZA NO	1 10 105	20 NO
of Vital I Physician: this certifica ral director, I	1 Yes No Hosp	Inpatient 2 4		t 3 🗆 DOA Othe	er: 4 🗌 Nursing H	ome 5 Resid	lence 6	Other (Specif	v)
ivision of or Attending P after death. Director, After thin by the funeral in by the funeral certificate:	27. Manner of Death Natural 5 Pending P	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work M 1	yat ? Yes 2 □ No	28d. Describe h	ow injury	occurred	
Division Bio or Attendi	3 Suicide 6 Could not be	28e. Place of Injury - At hor building, etc. (Specify)						Number or Rura	I Route Number,
					0	City or Tow			(
ne Hospita in 24 hours ne Funeral pleted fillec	(Check 2 L Medical Examiner:	n: To the best of my knowle On the basis of examination actioner: To the beat of my	and/or investi	gation, in my opinio	on, death occurred :	at the time, date a	nd place,	and due to the ca	use(s) and manner stated.
To the withir comp	29b. Signature and title of certifier	1 /-	/	29c. License		and due to th		e signed (Month,	
	1 (Glaves)	1. Bush	0	194	280C			6/12	
カオー	30. Name and address of person who comp	leted cause of death (Item	23a) (Type/P	rint)	and	411/	1/1	11/2/1	700
State	31. Date filed (Month Day Year) 4 2011	32. registrar's Signatu	8 6	ake	709,	1010	MA		71

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 6. 2011 2:05 Рм Hager, Sr. Lowell Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia Gilchrist Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Hours 03-10-10-1934 West^(y)Virginia 234-48-1221 77 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f shor Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20794 8339 Peachwood 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 3 1 X Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify. "natural", 3 Widowed 4 Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Industrial Cooling Shipping Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Juanita Radford William French Hager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8339 Peachwood, Jessup, Maryland Brenda L. Hager - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Meadowridge Mem Park: 06-13-2011 4 Donation 5 Other (Specify) Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line STROKE Immediate Cause (Final Physician/ disease or condition resulting in death) DAYS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Year Day 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ PERIPHERAL VASCULAR DISEASE Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 N 2 🗌 No this certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ျ ☐ Nursing Home 5 ☐ Residence 6 Nother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Funeral Director; After the 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after hours Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed. 24 3 Certifying Nurse Practioner, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one within 2 To the I 29b. Signature and title of certifie D64395 JUNE 9, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEDAR LANE COLUMBIA, MD 21044 6336 DANIEUE DOBERMANIMO 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ REGINALD HILL 26 MAL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nova PITOI If Under 1 Year | If Under 24 Hrs Social Security Number last birthday 9. Birthplace (State or Foreign Funeral 1/19/12/34/14964 Months Hours 578-88-1096 46 Yrs Director Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 X Yes 2 No 14DPRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral STATES UNITED 20743 714 NOVA AVENUE items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married "natural", or Completed by 72 hours after 2 No Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation...... Elementary/Seconday (0-12) College (1-4 or 5+) MUSICIAN PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ REGINALD D. HILL ROSALIE BALLINGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1159 SUMNER RD S.E. WASH., DC 20020 WANDA BROOKINS/AUNT Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CREM 6/2/11 BELTSVILLE, of Funeral Servi 22. Name and Address of Facility CAPITOL MORTUARY Signal MARYLAND AVE., NE WASHINGTON, 1425 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. Ust only one cause on each line, Interval Between set and Death Immediate Cause (Final Arteriose Fuysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami pue that initiated events Due to (or as a consequence of) resulting in death) Last bunialattending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 🗌 No detached g Unknown 9 Unknown P.O. sate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐XNo completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director; After Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Arthur Miles Jefferson June 20**1°1** 7:35 Рм Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Gardens Nursing Home Baltimore N/A5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Country) Virginia Months Days 1 XM 2 | F 210-36-9349 Hours Min. May 29 1943 Director 68 Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland 10a. State 10b. County Examiner must be notified at 10c, City, Town or Location Director 10d. Inside City Limits Maryland N/ABaltimore City 1 X Yes 2 □ No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 200 Cross Keys Road, Unit 27 21210 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force ō Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3
Widowed 4
Divorced If Yes. Give Black Completed Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Lawyer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Ruppert Jefferson Mary Alice Gillespie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.s</u> Health tem 27 D'Jana Goodspeed / Daughter 12707 Old Marlboro Pike, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory Inc. 06/13/2011 20c. Location - City or Town, State permit, Page 1
Department of Important: If it any injury or o ₫ 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Alvson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or in that initiated events and resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No 1 Yes 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Certificate: To 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident 2 🗆 No s after death Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined within 24 hours a hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗌 29b. Signature and title of cert 29c. License number D0069314 06 | 13 | 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mittal Rajanah 8813 Wallham Wood Rd. Parlattle MD 21234 31. Date filed (Month, Day, Year, 32. Registrar's Signature State JUN 1 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Paul Month Year 4:39 Johansen June 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Maryland Medical Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth April 23, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** Days 1**x**x M 2 □ F 215-08-7558 1970 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 1 ☐ Yes 2XX No MD Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 712 McKnew Avenue, Apt. #4 21054 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Dispatcher Cab Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Carmela D. Ambrosio Albert Paul Johansen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmela D. Crampton - mother 1113 Double Chestnut Crt., Curtis Bay, MD 21226 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 06 13-2011 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cardiac Tachydyschythmia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypovenhlation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami s been signed by the attending physician and should be detached for use as the burial-transit Morbid Obesit Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate beread hours after death.

Funeral Director: After this certificate has been signed by the attending obvisivis P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Abscess Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) D22247 June 10, 2011 Bu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Jason Oh

31. Date filed (Month, Day, Year)

4 2011

22

South

32. Registrar's Signature

Greene Street

Baltimore

MD 21201

State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 06-04-2011 10:20 P M Allbritton Johnson Joan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** Seasons Hospice Randallstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F $12^{\frac{Manth}{2}} \cdot \frac{Day}{2} \cdot \frac{Vea}{3} = 12^{\frac{1}{2}} \cdot \frac{Vea}{3} = 12^$ ^{Coupta)}orida Director 219-30-5749 76 Usual Residence of Decedent f show 10a. State 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Baltimore MD Anne Arundel 10e, Street and Number 10g. Citizen of What Country? Completed by Funeral United States 21225 102 13th Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Specify: 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiens important: If item 27 is marked other than any injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Tetterton Roy Allbritton Ruby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 13th Avenue, Baltimore, Maryland 21225 Bill Johnson - spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 🟋 Burial 2 🗌 Cremation 3 🗋 Removal from State Elkridge, Maryland Meadowridge Mem. Prk. 06-08-2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 13 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the hini Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2-1 No 1 Yes Other: 4 \sum Nursing Home 5 \sum Residence 6 Other (Specify) The head မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number DA7683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aven Ballmere MA 21209 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ June 11 Pay 2011 Richard 6:54 Рм Α. Knights Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth . Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** NOV . 3 Min United Kingdom Days 215-96-2933 76 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c, City, Town or Location ural", or items 23a or 28a-f sho I Examiner must be notified at within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🔯 No Maryland Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United Kingdom Funeral 118 Dock Street 21401 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married 2**X** No "natural", or ð ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) Boat Rigger Boats Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Knights Eileen Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Flat 2 127 High St., Poole, Dorset BH151AN, England Ian Knights / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/13/2011 Baltimore, Maryland Metro Crematory Inc. 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Alyson K Taylor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician on disease or condition eum Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 2 No 9 Unknown 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 မ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation completed filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number d 9 6 erson who completed cause of death (Item_23a) (Type, Print) 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 4 2011 Registrar

DHMH 17 Rev 7/2009

Physician /Medical Examiner Examin

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm. Modical Evaminer must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

10a. State

Director

Funeral

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attending physician and for use as the burial-transit certificate has been signed by the a rector, page 2 should be detached it Hospital or Attending Physician: Medical Certification: To filled in by the funeral e Funeral Director:

Completed by Physician/Medical

Be

P.O. Box 68760.

Division of Vital Records,

3 LI OTIKITOWIT												
Part II. Other significant condition	ons cor	ntributing to death but not res	ulting in the underly	ing cau	se given in Pari	t I.		se contribute to the cause of death? No 3 Probably 4 Unknown				
			<u>.</u>				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No				
25. Was case referred to medical			ce of Death	(Check only one)								
examiner? 1∰Yes 2 ☐ No	H	lospital: 1 ☐ Inpatient 2 ☐	R/Outpatient 3	DOA	Nursing Hom	ne 5 🗆 Residence 6	S □Other (Specify)					
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	ation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	280	Injury at Work? 1 ☐ Yes 2 [1	28d. Describe how injury occurred					
3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fa	ctory, o	ffice	2	8f. Location (Street and City or Town, State)	d Number or Rural Route Number,				
		sician: To the best of my knoner: On the basis of examinating and manner stated.						and manner as stated. place, and due to the cause(s)				
				00- 1	In a second second		204 Dat	a singed (March Day Voor)				

900 South Caton Avenue Baltimore

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alejandro MD 32. Registrar's Signature

31. Date filed (Month, Day, Year) 14

Darks

Funeral 75 204-28-8714 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar haust be notified at Director Parkville Md. Balto. 10f. Zip Code 10e. Street and Number 21234 8800 Walther Blvd. #4505 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or ite 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Engineer 17. Father's Name (First, Middle, Last) Be Julia Grischonis William Kurtinitis ပ 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 8800 Walther Blvd. Dolores Kirtinitis Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith 21. Signature of Funeral Service Licensee Immediate Cause (Final **Physician** a.Intracrania disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner reprovascula Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown

6-13-2011 Balto. Md. Schimunek Funeral Home 22. Name and Address of Facility Nottingham, Md. 21236 9705 Belair Road Approximate Interval Between Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed' 1 ☐Yes 2 ☑No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 9000 Franklin Square Baltimore, MD21237 Drive **ORIGINAL**

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Registrar

nours after death.

neral Director: After this y filled in by the funeral di

e Funeral

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Completed by

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Certification: To

Medical

DHMH 17 Rev 1/2001

Certificate of Death

2. Date of Death Month 6

Year 2011

4c. County of Death

3. Time of Death 20

Ronald John Kirtinitis

1. Decedent's Name (First, Middle, Last)

Social Security Number

1 - For State Registrar

Physician

Examiner

/Medical

4a. Facility Name (If not institution, give street and number) ranklin Square

1405 Pita 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F

o S C C Months Days

4b. City, Town, or Location of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene []

> Hours Min.

8. Date of Birth (Month, Day, Year) April 5,1936

9. Birthplace (State or Foreign Country) Pennsylvania

10d. Inside City Limits

1 □ Yes 2 □ No

IISA 14. Race - American Indian,

Black, White, etc.

10g. Citizen of What Country?

White Specify: 16b. Kind of Business/Industry

British Air Electronics

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #4505

Parkville, Md. 21234 20c. Location - City or Town, State

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementio

25. Was case referred to medical examiner?
1 ☐ res 2 ☐ No Hospital: 27. Manner of Death 1 Natural

5 ☐ Pending investigation

6 □ Could not be

28a. Date of Injury (Month, Day, Year)

3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

29b. Signature and title of certifier

2 Accident

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Ahmed 9000 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item# 20b, per fh. 26, per phy, 2916 6-14-11 sm State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JUNE 20^{ear}1 MARVIN S. KURLANDER 2:38 PN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE N/A SINAI HOSPITAL 7. Age (In yrs. last birthday) 73 Yrs Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Days Hours Min. 11/14/1937 219-32-3863 MD Director Usual Residence of Decedent show r 28a-f shorn 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r ō Completed by Funeral USA 3011 FALLSTAFF ROAD #305A 21209 ed other than "natural", or items event, the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. ELECTRICAL CONTRACTOR CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ KURLANDER PINSON WILLIAM IDA nt of Health and Ment: t: If item 27 is marker or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3011 FALLSTAFF ROAD #305A, BALTIMORE, MD 21209 ANN KURLANDER/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. MOSES MONT FFIORE WOSES MONT FFIORE WOODFFOR HEBREW 1 X Burial 2 Cremation 3 Removal from State 6/10/2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Aspination Pneumonic disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Coronary orten Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transli Cause (Disease or linjury Con estive that initiated events Due to (or as a con quence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypercoaqubble stete, Type 1 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an End stage henal disease autopsy performed death? 1 Tes 2 No 25. Was case referred to medical examiner?

1 \sum Yes 2 \sum No 26. Place of Death (Check only one) Other: 4 🗆 Nursing Home 5 Arcsidence 6 🗀 Other (Specify) Hospital: Certificate: To 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) D40371 6/9/11 'Dan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Late Drie Baltimac, 10 21209 Dr Harry W. Kaplanin Quarry 31. Date filed (Month, Day, Year) State 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 7, 2011 12:28 P M Bissett Mary Koesterer Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 5791 Elkridge Heights Road Howard Elkridge Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 🗓 F 07-23-1917 Yrs 93 Director 216-12-2579 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Il Hygiene. Jother than "natural", or items 23a or vent, the Medical Examiner must be r Funeral 5791 Elkridge Heights Road 21075 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: 3 Midowed 4 □ Divorced Specify. Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Retail event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o 0 Elizabeth G. O'Donnell Ewen Joseph Fraser permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic , once. other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 East Lexington St, #201, Baltimore, MD 21202 Harold H. Burns, Jr. - cousin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Meadowridge Mem. Park 06-11-2011 4 Donation 5 Other (Specify) Elkridge, Maryland 21. Signature of Funeral Service Li 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between DEBILITY Onset and Death Immediate Cause (Final Physician/ EARS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ZHEIMER EARS DEMENTIA Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine HYPERTENSION Cause (Disease or linjury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 signed by the a detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, STEOARTHRITIS 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law page 2 s autopsy within 24 hours after death.

To the Funeral Director; After this certificate i completed filled in by the funeral director, pag 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2 No 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: Natural 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗑 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number 22832 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar SOON

JUN 1 4 2011

5808 MAIN STREET, ELKRIDGE, MD 21075

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Willie James 2011 Leonard 12:30A M June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Laurel Wood Nursing Center E1kton Ceci1 **Funeral** Social Security Number Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days Hours (Month, Day, Year 86 Director 26**7-**20-7086 Georgia Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director GA Chris Cordele 1 Tes 2 No 10e. Street and Number 10f. Zip Code Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or Important: If item 27 is marked other than "natural", or items 23a or pray injury or other traumatic event, the Medical Examiner must be none. 10g. Citizen of What Country? Funeral 1106 South 9th St. 31015 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2XXNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. If Yes, Give 3 X Widowed 4 Divorced Black Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Food Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ (Unknown) Leonard Minnie Linton Bel1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Linton / Niece 90 Waverley Dr. Apt.(S) #303, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Uniformed Sers. Univ. 06/10/2011 Bethesda, MD 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ 10 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine as a consequence of). attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: signed by the attendin the detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ☐ Pregnant at time of death
☐ Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown in 24 hours after death.

The Funeral Director: After this certificate has been singleted filled in by the funeral director, p. ge 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 4 Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🖳 No Other မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Wursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 123 SINGERLY AVE, ELKTON MD 2192 EL

State Registrar

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item# 26 per phy, g916 6-14-1 sm State of Maryland / Department of Health and Mental Hygiene amend #10a-f Per INF G918 8/02/2011 JH Certificate of Death Reg. No. 20 18763																
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11-04215 Carolyn Little-Jackson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12, 20°11 June Faye A. Marrapodi 4:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harmony Hall Assisted Living Howard Columbia Social Security Number 8. Date of Birth Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🎛 F Days Min. Months Hours 08/11/2011 Country) 154-03-7283 NY Director 99 Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Prince George's Laurel 1X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 0 10g. Citizen of What Country? pe Funeral "natural", or items 23a edical Examiner must b 8712 Crystal Rock Lane 20708 U.S.A. Page 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes Give Specify: 3

Widowed 4 □ Divorced White Completed Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Clothing Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unk Michelo DeVito Friggola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Marrapodi 8712 Crystal Rock Ln, Laurel, MD 20708 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otf Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Donation Donation 5 Other (Specify) 06/17/2011 Bound Brook, NJ Bound Brook Cem. 22. Name and Address of Facility Signatur Branchburg Funeral Home 910 US HWY 202, Branchburg, NJ 08876 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Dementig Immediate Cause (Final 17/2 hermers Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FÉMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Yes 2 No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an has autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No this certificate within 24 hours after death.

To the Funeral Director, After this certifical completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 100 Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending Natural work?
1 \sum Yes 2 \sum No 2 Accident 3 ☐ Suicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one 29b. Signature and ti e of certifier 0 de 30. Name and add person who completed cause of death (Item 23a) (Type, Print) edan 6334 CIND 2615 32. Registrar's Signature JUN 1 4 2011 Registrar

11-04	328
Rvan	Morton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	-uneral Director		5. Social Security Numbe 050-74-695		7. Ag	e (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days		Min.	Date of Bird		Foreig	thplace (State or in untry) New York	
			Usual Residence of Dece	dent							oury 2		1704		
	OW any		1	County		10c. City, Tov								10d. Inside City Limits  1 Yes 2 X No	
ļ	Maryland 28a-f show	Director	New York Re 10e. Street and Number	ensselae	<u>r</u>	Wynan	tskil	L 10f. Zip Code			10	Og. Citize	en of What Cour		
	with the Maryland ns 23a or 28a-f sho be notified at once	Dire	106 Edwards	s Road				12198				US	<u>'</u> Δ		
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93	E - F	mp	Landscaper Landscaper Landscaper												
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212	should be in and Mental I 7 is marked natic event, 1	To B	19a. Informant's Name/Re	or Town, State	Zip Code)										
₽:	d 2 sho lth and n 27 is	19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steven D. Morton / Father   106 Edwards Road, Wynantskill, NY 12													
ē,	Pages I and 2 shou ment of Health and N tant: If item 27 is n or other traumatie		20a. Method of Dispositio		Removal from St		e of Disposit atory or other	ion (Name of cen er place)	netery,	Da	ate	20c. Lc	ocation - City or	Town, State	
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Ba	permit. Pages I and Z shoul Department of Health and M Important: If item 27 is m injury or other traumatie		21. Signature of Funeral S	1 ( A	Pull	1,	Mo	me end Address Comas Fu 17 Cokes	neral	Home	P.A	ao b	MD 210	00	
	ysician		23a. Part I, Enter the dise failure. List only one			the death. Do								Approximate Interval Between Onset and	
	dedicul aminer	3 1	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):												
				. 500	to (or as a cons	equence of):									
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928	nuncating phy as the	- 21	IF FEMALE: 23b. Was decedent pregna past 12 months?	ant in the	3c. If yes, outcor Live birth	ne of pregnand		ideath 3	Ectopic pr	egnancy			Date of delivery Sonth D	ay Year	
Box 6876	eath certificate attending phy for use as the b	73	1 Yes 2 No 9	Unknown 6	Pregnant at	time of death	5 Othe	er (Specify)				Ì			
. B	that the de ned by the detached f	Physic	Part II. Other significant			n but not result	ing in the un	derlying cause gi	ven in Part I.		23e. Did to	pacco us	se contribute to t	he cause of death?	
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spic	w requisited to the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of	plete								_	24a, Was a autops	sy	prior to c	opsy findings available ompletion of cause of	
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雪	ysician: The his certificate director, page	Be (	25. Was case referred to examiner?		ital: 1 Innatie				of Death (Ch						
<u> </u>	ing rays After this funeral di	음	1 ✓ Yes 2 N 27. Manner of Death	No I	28a. Date of Inju	ry 28t	Outpatient o. Time of Inj		/ at Work?		Describe h		ce 6 Other	Scene	
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	를 <b>를 함</b> 등	edical	(Check only	ying Physician: ai Examiner: On	the basis of exa										
F	. \	Me	29b. Signature and title of		manner stated.			29c. License	number			29d. Da	ate signed (Mon	th, Day, Year)	
10	oborg		Cry 30 Norma and adding	W _	UP	a ath /lt as		O.C.N	1.E.			June	9, 2011		
	1,2h		30. Name and address of Ling Li, MD As	ssistant Medi	cal Examine	900 W.		Street, Balti	more, MD	21223	3				
	S Regis		31. Date filed (Month, Day	Y, Year)	32. Registra	's Signature	Ked								
			WANT TO	- John		17						OCME			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ *Month Jeannette Miller Medical 4a. Facility Name (if not institution, give street and number)
Good Samaritan Hospital 4b. City, Town, or Location of Death Baltimore **Examiner** 4c. County of Death 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo April 14, **Funeral** 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign 1 M 2 X F Hours 90 213-18-7851 Mary Land **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore **Baltimore** 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 Old Harford Road 21234 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates. Miller, Jecunett White 1 Yes 2 X No Specify 3 x Widowed 4 ☐ Divorced Specify: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)

Manager Elementary/Seconday (0-12) College (1-4 or 5+) Credit Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elsie Evelyn Grimes Louis Lewellyn Burroughs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 9532 Oakbranch Way, Baltimore, Maryland 21236 Carl Brian Miller Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6/16/2011 Lorraine Park Cemetery Woodlawn, Maryland Foneral Service Liger 22 Name and Address of Facility
Burgee Henss Seitz Funeral Home, Inc.
3631 Falls Road, Baltimore, Maryland 21. Signature 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate /al Betwee Immediate Cause (Final Physician/ neye disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if you had been cause. Enter Underlying Cause (Disease or linjury that initiated events southing in dooth). Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Heart Failure 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 No 3 Probably 4 Unknown he wscleyosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🖳 this 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred To the Hospitar ... within 24 hours after death.
To the Funeral Director: After and the funeral filled in by the fur Natural 5 Pending 1 Yes Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Gertifying Nur Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and 32. Regis onth. Day. Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 June 9:30 A M Neil F. Mason Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Cabin John 6406 78th Street Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 23, Hours 1 🕱 M 2 🗆 F 1949 Maryland Director 213-54-9055 61 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 🗌 Yes 2 🎇 No Maryland Montgomery Cabin John 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral United States 20818 6406 78th Street 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. or, þ 1 Never Married 2 X Married 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Image Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mary Middleton Robert Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6406 78th St. Cabin John, MD 20818 <u>Karen Mason / Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 6/15/2011 Woodbine, Maryland . Signature of Funeral Service Lice 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_{sician/} disease or condition resulting in death) Renal Cell Carcinoma year Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trans Jause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 2 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? __1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury Accident Investigation after death filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed it (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year, June 13, 2011 D26331 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 MacArthur Blvd. NW Washington, DC 20016 Marta Schneider

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

JUN 1 4 2011

Kirk Middledorf
11-04162 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) 3. Time of Death Kirk Edward Middledorf Month Medical Examiner 0051 hrs June 3, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Edgewood Anne Arundel Route 2 & Harwood Road 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) Funeral 216-04-8163 Min Foreign Country) MD Hours 07/12/1963 43 Months Days Director 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. Count 10c. City, Town or Location e notified at once. Edgewater MD Anne Arundel 1 X Yes 2 No death with the Maryland Director 10f. Zip Code 21037 10g. Citizen of What Country USA 10e. Street and Number 1618 Bentley Road Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, t. T. Pages I and 2 should be filed within 72 hours after death wir frment of Health and Mental Hygiene. retant: If item 27 is marked other than "natural", or items y or other traumatic event, the Medical Examiner must be. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1XXNever Married 2 Married Yes Specify: White 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Yeer ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Technician Fire Prevention 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kirk Middledorf Mary Westman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1618 Bentley Rd., Edgewater, MD 21037 19a. Informant's Name/Relationship (Type, Print Teresa Middledorf/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State rematory or other place)
Final Journey Crem. 1 Burial 2 Cremation 3 Removal from State 6/11/2011 Woodbine, MD 4 Donation 5 Other Specify. 22. Name and Address of Eacility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall Depart Impor ushall 21203 Approximate Interval **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and failure. List only one cause on each line Medical aMultiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Division of Vital Records, P.O. Box 6876u, and ca 23a,27,28a-f,per me,g916 6-15-11 sm **X** AMENDED X UNPENDED signed by the attending physician be detached for use as the burial hysician/Medi 16a.b.21 per fh g916 6-17-11 vt 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnanc 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Month Fetal death Day 2 _ Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 굽 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ē 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed ficate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director;

IOK pend 30. Name and address of person who completed cause of death (Item 23a)

Registra

Certification:

Medical

filled in by

examiner?

1 Natural

2 X Accident

3 Suicide

4 Homicide

29b. Signature and title of certifier

1 V Yes

27. Manner of Death

2 No

5 Pending

Investigation

Could not be determined

Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) JUN

32. Registrar's Signature

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury

fd 6-3-11

(Specify) road

and manner stated

Other Nursing Home 5 Residence 6 🗸 Other: Scene

driver in collision

28d. Describe how injury occurred

in auto/fixed object

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)Rt 2 and Harwood Rd. Edgewater, Md.

June 3, 2011

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc

fd 12:43 pm

29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

29c. License number

O.C.M.E.

1 Yes 2 X No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ 8:22 PM an Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Raven Age (In yrs. last birthday) g. Birthplace (State or Foreign 8. Date of Birth If Under 24 Hrs. **Funeral** 216-50-4104 1 M 2 □ F Country) Months Hours 10/37 1947 Director Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director Baltimore 1 X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA South Ann Street 21231 24 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 NA rmy
If Yes, Give
Year or Dates.1 966-67 Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 ☐ Yes 2 No Specify Specify. White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed withIn 72 Is and Mental Hygiene.

7 Is marked other than "r within 72 Elementary/Seconday (0-12) College (1-4 or 5+) Local Government Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ма≋у Barron Stanley R. Monroe permit. Page 1 and 2 should be in Department of Health and Ments Important: If item 27 Is marked injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 S. Ann Street, Baltimore, MD 21231 19a. Informant's Name/Relationship (Type, Print) Sheila Monroe/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 6/12/2011 Woodbine, MD Final Journey crem 4 Donation 5 Other (Specify) ^{22. Name and Address of Facility}
Maryland Cremation Services
PO Box 1413, Baltimore, MD Signature of Funeral Service Licensee Dorota Marshall 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysiciani unknow21 disease or condition a Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last burial-1 attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav 5 Other (specify) the 9 Unknown Division of Vital Records, P.O. signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director; After this certificate has b performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the I within 2 To the I 29b. Signature and tixt of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 loward, Baltimore, Maryland

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Milton Physician/ George Marks Month Ам Medical 12 2011 une 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore **Examiner** 4b. City, Town, or Location of Death Towson Gilchrist Hospice Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months (Month, Day, Year) 07/27/1948 093-36-7636 1 🔀 M 2 🗆 F Country) Director 62 NY Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a MD Baltimore Cockeysville 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10303 Malcolm Circle #H 21030 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Examiner 14. Race - American Indian Black, White, etc. ō ò 12 Yes 2 No June 68 If Yes, Give Year or Dates. – Dec . 68 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify. "natural", Completed 3 Widowed 4 Divorced Specify: Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Travel Travel Agent traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Milton Marks Attenbarough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10303 Malcolm Circle, #H, Cockeysville, MD Department of Health ar Important: If item 27 is any injury or other trau once. Linda M. Marks / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Final JourneyCrem. 1 Burial 2 Cremation 3 Removal from State 6/15/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, Mi) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Dav Year the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performe Yes 2 No 1 🗌 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Yes မ Director: After this I in by the funeral dir 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 2 Accident (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Funeral Direct completed filled in by 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the A Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nly one 00071287 6-12-11 ss of person who completed cause of death (Item 23a) (Type, Print) St. Suite 4105 Baltimere, Mo 21204 0 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No./ 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4:10 P M June 2011 10. MERRILL 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Months Days 1 □ M 2 🔀 F 78 549-49-9593 Dec. 4, 1932 Korea Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No College Park MD Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5011 Odessa Rd. 20740 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ੴNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Asian Specify: 3 ₩Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Un Pyong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gabriel Merrill / Step-son 5011 Odessa Rd., College Park, MD 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 27 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 5 ☐ Other (Specify) 06/14/2011 Beltsville, MD 4 Donation 22. Name and Address of Facility
Rapp Funeral and Cremation Services M00382 933 Gist Ave., Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE RENAL FAILURE WEEKS Due to (or as a consequence of): ALZHEIMER'S DEMENTIA YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinat must be multified at any injury or other traumatic event, I'm Medical Examinat must be multified at appear.

Baltimore, Maryland 21215-0036

Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar nours after death.

neral Director: After this
filled in by the funeral di within 24 hours a

Division of Vital Records, P.O. Box 68760

ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque c.	mea of):			
resulting in death) Last	Due to (or as a conseque	ence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions of	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of the pregnant at time of de 9 □ Unknown	death 3 Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resul	ting in the underlying	cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?  2 14 No 3 Probably 4 Unknown
				24a. Was an autopsy performed' 1 ∐Yes 2 🔼	
25. Was case referred to medical			26. Place of De	eath (Check only one)	
	Hospital: 1 Language 1	R/Outpatient 3	DOA Other: 4 In Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)
	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
27. Manner of Death  1. Natural 5   Pending 2   Accident investigation 3   Suicide 6   Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, facto	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying Ph	yslcian: To the best of my know niner: On the basis of examinati and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier		2	29c. License number	29d.	Date signed (Month, Day, Year)

D 0065485

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20910

State Registrar

1500 FOREST GLEN RD., SILVER SPRING, MD BARBARA SEPANICK M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4

BM MD

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year MANUEL SOMDRA LEE 6:26PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORF HARBOR HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 10, 1956 9. Birthplace (State or Foreign Country) Athens, Greece Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days 1 □ M 2 🕅 F Months Hours 54 Director 218-76-7741 Usual Residence of Decedent 28a-f show 10h. County 10a, State 10c. City, Town or Location Director must be notified Maryland Baltimore Rosedale 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 5403 Canonbury Road 21237 United States items death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō 1X Never Married 2 Married within 72 hours after ģ 1 Yes 2 XNo If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Harry Manuel Evelyn Fields other traumatic permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Bukowski (Friend) 5403 Canonbury Road, Rosedale, Maryland 21237 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Dulaney Valley Memorial
Carcers 1 💆 Burial 2 □ Cremation 3 □ Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Funeral Chapel & Crematico

8800 Harford Road Parkville.

23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 any Approximate Physician ADENOCARCINOMA WITH PERIZOMEAL disease or condition PANCREATIC Medical resulting in death) Due to (or as a consequence of): CARCINOMATOSIS Examiner ASCITES Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and -transit PORTAL TITROMBOSI VEIN Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE: ISe 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ó Month Year detached 9 Unknown P.O. s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTEMSION Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed' certificate Yes 2 No 1 ☐ Yes 2 🔀 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes 2 No မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 M Natural 5 Pending s after death. 1 Yes 2 No Investigation 6 Could not be Accident the Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined 24 hours a Hospital Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 Certifying Nurse Practioner To the best of my knowledge, death promised at the time, date and place, and due to the neuros(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D CPayi RES 001 q 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 3001 SOUTH HANOVER STREET BALTIMORE ADITYA SAIMI 31. Date filed (Month, Day, Year) 32. Registrar's Signature 21225

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Sophia Miller 4:18 P M JUNT Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SEASONS HOSPICE @ NORTHWEST HOSPITA RANDALLSTOWN BALTIMORE **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 🔽 F Hours 92 Director 215-09-9395 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director ms 23a or 28a-f s must be notified 1 X Yes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>3012 FALLSTAFF ROAD</u> 21209 ural", or items ? death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2√√ No Specify: Specify: WHITE "natural" 3 ¥ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) CERTIFIED PUBLIC ACCOUNT ACCOUNTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hitem 27 is marked of ပ Page 1 and 2 should be MINNIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS CAROL WAGNER/DAUGHTER 2928 MARNAT ROAD, APT. A. BALTIMORE. t of Healt : If item ' 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of Important: If any injury or Burial 2 Cremation 3 Removal from State BETH TFILOH CEMETERY : 06/12/2011 BALTIMORE. MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD PIKESVILLE. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cardioThrombotic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Curdiovasiular Discase Atheros Clerotic Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? performed? After this certificate 2 🗌 No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica director, 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Pother Specific nt unit has processed 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Natural iniury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MS Ray apalose M'D 105h D0057465 Baltimore MD Z1209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NS Raja Pakse IM. D 2835 Smith 5-203 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 4 2011 Darks Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ June H 08^{ay} 2011 Matkins Clinton Samue1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore 9525 Oakbranch Way Nottingham 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Min. April Io, ^{Year}1960 1 X M 2 D F Months Hours North Carolina 239-25-6156 **Director** 51 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location notified at Director Maryland Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral U.S.A. 21236 9525 Oakbranch Way 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Specify: White Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Musician Music traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Edward Matkins Not Known 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra 9525 Oakbranch Way, Nottingham MD 21236 Patricia Matkins/ wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery 106/14/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Ruck Towson Funera. 1050 York Rd. Towso Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e. ch line. 1050 York Rd. Towson, MD. Immediate Cause (Final Physician/ Athlevasoleratic cavalovasolar Eupertensing disease or condition Medical resulting in death) Due to (or / a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on). Exami Records, P.O. Box 68760 The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month signed by the a 2 🗌 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dearrheausthelectrolyte Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 19turbance 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2. No Yes To the Hospital or Attending Physician: **Division of Vital** within 24 hours after death. To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month Day, Year)

7:40 A M

10d. Inside City Limits

Approximate Interval Between Onset and Death

Dr. #211

1 Yes 2 X No

State Registrar

DHMH 17 Rev 7/2009

5009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tetrej (00 M.D 5009 Ho)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 11 JÜNE 11:45 AM Merryman Adrian H. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Jan. 20 Ye1 923 Mary Land 1 □x M 2 □ F 88 214-22-2077 Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Yes 2X No Stevenson Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 21153 MERRYMAN, Adelan Baltimore, Maryland 21215-0036 2111 Our Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? þ 1 Never Married 2 X Married White 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: Completed 3 🗌 Widowed 4 🗌 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Bendix Radio Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Wright Nicholas Bosley Merryman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stevenson, Maryland 21153 2111 Our Lane Joan Merryman / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 6-10-11 Towson, Maryland 4 Donation 5 Other (Specify) Hilltop Service Corp. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronan disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death cate has been signed by the a page 2 should be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 🔲 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ျှ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: Manner of Death 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

the

State Registrar only one

and address of person who completed cause of death (Item 23a) (Type,

0

29d. Date signed (Month, Day, Year)

OWSON

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Minor William /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) Feb. 15, 1 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex 1 X M 2 X F . Age (In yrs. last birthday) 5. Social Security Number Months Days Hours **Funeral** 1924 Arkansas 87 Feb. 430-32-2611 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 10a. State or 28a-f show 1 ☐ Yes 2 XNo traumatic event, the Medical Examiner must be notified at Director MD Baltimore Timonium 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 21093 USA 12261 Roundwood Road #1304 'natural", or items 23a Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No
If Yes, Give
Year or Dates: filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Baltimore, Maryland 21215-0036 Completed by 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event to once. Elementary/Secondary (0-12) College (1-4 or 5+) IRS Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella Webb J. Luther Minor, Sr. မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 303 Valleyview Garth; Timonium, MD 21093 Lloyd Minor son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date unk 20a. Method of Disposition 1 N Burial 2 Cremation 3 ☐ Removal from State Oakland Cemetery Atkins, AR Other (Specify) 4 Donation 22. Name and Address of Facility 21. Signature of F 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau on each line Immediate Cause (Final ongestive **Physician** disease or condition resulting in death) )/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of) physician and is the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Live birth Month in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 3 Probably 4 Unknown 1 🗌 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 🗌 ER/Outpatient 3 DOA မှ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Certification: Natural 2 Accident eral Director: After filled in by the fune 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined 3 Suicide 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my online, death occurred at the time date. 24 hours a 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

State Registrar

ugenie 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month HOWARD 2011 ALLEN NASH 1:48 P M JUNE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8612 Rayburn Rd. Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Months Hours Min. 1 😾 M 2 🗆 F 104-28-7703 New York 73 **Director** 1937 Nov. Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director MD Montgomery 1 ☐ Yes 🏋 🛱 No Bethesda 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8612 Rayburn Rd. 20817 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mussonce. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1964–68 1 ☐ Yes 2XXNo Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Scientist Mental Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harvey Nash Harriet Ratner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dominie M. Nash / Wife 8612 Rayburn Rd., Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory | 6/14/2011 Beltsville, MD Signature of Funeral Service Lice Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00382 23a. Part 1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20910 Approximate Interval Between Onset and Death 2 YEARS Immediate Cause (Final Physician RENAL CELL CARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or linjury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 5 Other (specify) g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ XX No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5XXResidence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1**XX**Natural 5 Pending injury 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature ap<del>d ti</del> 29c. License number 29d. Date signed (Month, Day, Year, D23556 June 13, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 7/2009

Registrar

ROBERT H. BLEE M.D.,

JUN 1

4 201

31. Date filed (Month, Day, Year)

8530 WISCONSIN AVE. #1400, CHEVY CHASE MD

20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	laryland	-	artmen rtificat				1	Reg. No	0	18779	
	Physici	20	1. Decedent's Name (First, Middle, Last								<ol><li>Oate of De _Month</li></ol>	ath Day 9	Year	3. Time of Death	
	/Medic		Cornelia Creel (				1				June		Year 20]		
1	Examin	er	4a. Facility Name (If not institution, give				4b. City,		Location o			4c. C	County of Oea		
			Charlestown Retire				If Under		ONSV		8. Date of Bird	b	Balti	thplace (State or Foreign	
	Funeral		5. Social Security Number 6. Se 214–26–1904	х ]м 2√2]F	ige (In yrs. la 83	Yrs.	Months	Days	Hours	Min	Month, Da	y, Year)	New York		
	Director		Usual Residence of Decedent	Λ	03					l.	sept. 1	. , 1	741	MEM TOTA	
	Maryland a-f show	tor	10a. State 10b. County Maryland Balti	more	10c. City,	, Town or Lo		aton	svill	e				10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	with the	Funeral Director	10e. Street and Number 707 Maiden Choice	Lane. A	ot. 72	09	10f. Zip	Code	212	28		_	en of What Co	-	
	death	era	11. Marital Status	12. Was Deceden	t Ever in U.S		Was Dece	dent of Hi	spanic Ori	gin? (Spec	cify Yes or No Rican, etc.)	. 1	4. Race - Am		
က္	after or less		1 Never Married 2 Married	Armed Forces	J-No					, Puerto F	tican, etc.)	1	Black, Whi		
<u>8</u>	ref', c	by	3 Widowed 4 □ Divorced	If Yes, Give 4 Year or Dates	: L		1 🗌 Yes	21X NO	Specify:			,	Specify:	White	
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If Item 22a or 28a-f show may inportant: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other treumatic event, Ite Medical Examinar must be notified an page.	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4o		16a. Dece (Give life.	kind of wo DO NOT u	rk done a	turing most	t of workin	g	Fair	d of Business fax Co ic Sch	unty	
Maryland 2	2 should be filed and Mental Hygin is marked other reumatic event, III	17. Father's Name (First, Middle, Last) Buckner Miller Creel  Buckner Miller Creel  Margaret Cameron													
Mary	id 2 shoulth and M		19a. Informant's Name/Relationship (Type, Print)  Claire O'Neill / Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zipe 6 Rolling Farm Ct., Catonsville, Maryland												
lore,	iges 1 er nt of Hea if Item :		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		Ce	ace of Dispo	matory`or (	other plac		-	ate 5 / 2011		ation - City of		
Baltimore,	permit. Pages 1 end. Department of Health Important: If Item 27 any injury or other tr pnca.	Arlington Nat'l Cem. 07/05/2011 Ft. Myer, Virgos Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility MacNabb Funeral Home, P. 301 Frederick Rd., Catonsville, MD 21228													
	40260	$\vdash$	23a. Part1. Enter the disease, or comp	lications that cause	ed the death								, MD 2	1 Z Z O Approximate	
50	Physician /Medical		shock, or heart lailure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Scholl	line.	,		10	9, 000					Interval Between Onset and Death	
П	Examiner			b. Attore											
	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	is a consequ	ence of):	2790								
8760,	ate be executed thysicien and the burial-transit	icai		d	13 4 50113545	ende dij.									
P.O. Box 68	The law requires thet the death certifical sie hes been signed by the ettending phy bage 2 should be deteched for use as in	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal at time of de	death 3[	∃Ectopic p ∃ Other (s _i					2	3d. Oate of de Month	elivery Day Year	
ds, P.	uires thet if signed by id be detec	Ď	Part II. Other significant conditions co	ntnbuting to death	but not resu	Iting in the u	ınderlying	cause give	en in Part I		23e. Did			to the cause of death?	
Records,	The law requir cete hes been si page 2 should is	Completed										psy ormed?	prior to death?		
		Ö	25. Was case referred to medical						26 Place	of Doath	1 ☐ Yes (Check only	2 No	1 🗆 Ye	s 2□No	
>	Physician: this certifical ral director,	To B	eyaminer?	Hospital:	itient 2 🗆 E	EB/Qutpatie	nt 3 D	OA Oth	er -		ne 5□Res		□Other (So	acıfu)	
	nding Phy ath. r: After this e funeral c		27. Mann Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Ir		28b. Time o Injury		28c. Injun Wor		2	28d. Describe			outy)	
Division	To the Hospital or Attending I within 24 hours after death.  To the Funerel Director: Atter completely filled in by the funer	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of I	Injury - At ho etc. (Specify	me, farm, st	reet, lactor	ry, office		2		(Street and wn, State)		Rural Route Number,	
,	To the Hospital within 24 hours To the Funerel completely filled	dical	29a. Certifier (Check only one) Certifying Physics 2 Medical Example 2	iner: On the basis	of examinat	ion and/or ir	rvestigation	n, in my o	pinion, dea	th occurre	ed at the time,	date and	place, and du	e to the cause(s)	
	To the To the Comp	M	29b. Signature and title of certifier		1		29	c. Licens	e number			29d. Date	signed (Mor	nth, Day, Year)	
	1		ay)	( /	Co			1006	3929	2		6	110/1	/	
9	->		30. Name and address of person who a	completed cause o	f death (Item	23a) (Type	Print)	den	Choice	0.	Cator	esver	1/e 1	nth, Day, Year) 1 10 21228	
	Sta Registi		31. Date liled (Month, Day, Year)	Server 32. Regis	strar's Signat	park	1								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201 Tea Physician/ Wilson Franklin Outen 9. 3:20A. M June Medical 4b. City, Town, or Location of Death Towson 4c. County of Death **Baltimore** 4a. Facility Name (if not institution, give street and number) **Examiner** Gilchrist Hospice If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Feb. 3, 1927 1 **K** M 2 □ F Months Hours 217-22-3506 Maryland 84 Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Baltimore Maryland Baltimore 1 🗌 Yes 2 🔀 No 10f. Zip Code 21234 10e. Street and Number 10g Citizen of What Country? United States 1704 Goodview Road Funeral of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 K Married þ Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Land Development permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Men College (1-4 or 5+) Elementary/Seconday (0-12) Services Civil Engineer 12 Be Mother's Name (First, Middle, Maiden Surname)

Myrtle Outen 17. Father's Name (First, Middle, Last) Raymond Outen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1517 Green Valley Court Bel Air, Maryland 21015 19a. Informant's Name/Relationship (Type, Print) Donna M. Roberts/daughter Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of June 10 cemetery crematory or other place)
Evans Funeral
Chapel—Bel Air 1 Burial 2 🛛 Cremation 3 D Removal from State Forest Hill, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fyleral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral & Chemation Center, P.A. Timmium, Maryland 21093 York Road 23a. Part 1. Inter the disease, or complications that passed shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner remema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death the g Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No -KI 3 Probably 4 Unknown Records, 1 🗌 Yes should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law i within 24 hours after death.

To the Funeral Director, After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 **1** No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🗌 Yes 2 🗆 No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4x1

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Year

cistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

9. Birthplace (State or Foreign

white

10d. Inside City Limits

Interval Between

Onset and Death

Day

29d. Date signed (Month, Day, Year)

BALTIMORE

Year

1 Yes 2XXNo

12:25 P.M

P.O. Records, Division of Vital

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State Registrar 29b. Signature ay

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31. Date filed (Month, Day, Year)

KUMAR

JUN 1 4 2011

DHMH 17 Rev 7/2009

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MD

CHARTES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701

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32. Registrar's Sig

29c. License number

710 40

SULTE 4105

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.														
Physici		Decedent's Name (	(First, Middle	Last)	•						2.	Date of De	ath Day	Yea		3. Time of Death
M≏dical Exami	ner	Vicki Ma	rie Pa	atten								June 9, 2		rea		2005 hrs
)		4a. Facility Name (if n Laurel Region		-	umber)	-	41	. City, To	vn, or Lo	ocation of	Death		- 1	c. County o		's
Funeral		5. Social Security Nur	<u> </u>	6. Sex	7. Age (In yrs	. last birt	hday)	If Under	1 Year	If Under	24Hrs.	8. Date of B				nplace (State or
Director		372-50-870	14	1 M 2 F		5	2 Yrs.	Months	Days	Hours	Min.	Oct.			Foreign	
		Usual Residence of D					2 110.			<u> </u>		OCL.	, L D	750		Michigan
ym /		10a. State 10	b. County		10c. Ci	ty, Town	or Location	1								10d. Inside City Limits
Maryland 28a-f show d at once.	ō	MD	Montgo	omery	Bu	rton	svill	.e								1 Yes 2 XXNo
Mary	Director	10e. Street and Numb	per					10f. Zip C	ode				10g. Cit	at Coun	try?	
h the	Ϊ́		oss Ri	iver Cour	t			2086	6				USA			
1215-0036 d be filed within 72 hours after death with the Maryland fental Hygiene. sarked other than "natural", or items 23a or 28a-f shoveret, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Married	2 X Mar		cedent Ever in orces?	U.S.				anic Origi Mexican, I		ify Yes or No can, etc.)	٥-	14. Race White		can Indian, Black,
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36 hin 7 e. edical	Completed														1 D	ogorda
od wir	ပ္ပ	12 Administrator Medica 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)												II K	ecorus	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be	John Col	leman						I	Doris	s Vic	k				
21 nould and Me is man	မ	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town,														
MOFE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. nnt: If item 27 is marked other than "matural", or items 23s or 28s-f shor other traumatic event, the Medical Examiner must be notified at once.		John A. P	·	Jr./Hus								·				MD 20866
Baltimore, permit. Pages I am Department of Heal Important: If iten		20a. Method of Dispos		3 Removal fr			f Dispositions or othe		of ceme	etery,		oate ne 11,		Location -	City or 1	Town, State
Page Page ment tent		4 Donation 5 Other Specify: West Arundel Crematory 2011 Odenton  21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral												•		
Baltimory permit. Pages 1 Department of 1 Important: If	- 1														e, P.A.	
		23. Part I. Enter the c			1053	th Dono						aurel				Approximate Interval
Physician //Medical		failure. List only	one cause of	n each line.					ıyırıy, su	uch as car	diac or re	spiratory an	est, sno	ock, or nea	ı	Approximate Interval Between Onset and
≟xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):												Death		
		Sequentially list condi	itions	b		0.7.										
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	Examiner	(Disease or injury that events resulting in dea	tinitiated	c. Due to (or as a	consequence	of):									_	
760, icate be executed physician and the burial - transit				d												
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial — trans	n/Medical	X UNPENDED		AMENDED 2	23a,27,	28a-	f,per	me,	917	7-1	-11 s	sm				
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certif	ä	past 12 months?	gnantintuo		irth ant at time of o		Fetal			Ectopic p	oregnancy	′		Month	Da	ay Year
Box 68760, e death certificate be ex the attending physician cd for use as the burial	Physiciar	1 Yes 2 No	9 🗹 Unkn			5	Othe	r (Specify								
P.O. I	4	Part II. Other significa	ant conditio	ns contributing to	death but not	resulting	in the und	lerlying ca	use give	en in Part	L	23e. Did t	obacco	use contrib	ute to th	ne cause of death?
ires that	d by											1 Ye	s 2	No 3	Proba	ably 4 🗹 Unknown
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LE TE		25. Was case referred	to medical	1				26.1	Place of	f Death (C	heck only		2	9 1	7 163	2 140
2 5 5 5 E	o Be	examiner?	No	Hospital: 1 1	npatient 2	ER/Ou	tpatient :	B DOA	Ot	ther ₄	Nursing H	lome 5	Reside	ence 6	Other:	
n of ding Ph	=	27. Manner of Death		28a. Date (Month	of Injury , Day, Year)	28b. T	ime of Inju	ry 28c	Injury a	at Work?	28	d. Describe	how inju	лу оссите	d	
Attendi	읉	1 Natural 5		9   Fd 6	-9-11	fd	7:03	pm 1	Yes	s 2 X N	•• U1	nknowr	1			
Division  Lial or Attendings after death.  The Director: A lled in by the fi	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural												Route Number, City			
Divi	Š															
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	igal	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Check only   1   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
To with To com	Medical	29b. Signature and title		and manner s					cense n							h, Day,Year)
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8 1	-	30. Name and address	of person w	ho completed cour	e of death (Ito	m 23a)		ــــــــــــــــــــــــــــــــــــــ							•	
OKAM		Zabiullah Ali, N		ssistant Medic		,	W. Bal	timore :	Street,	, Baltim	ore, MI	D 21223				
		31. Date filed (Month, L		32. Re	gistrar's Signa	ture							.,			
Regist	rar	JUN 1 4 20	011 /	Eneral,	B. 100	rke	7									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4 Day Physician/ June 201^{rea} 22:44 P M Joseph R. Pennell-Booth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth Funeral Social Security Number 6. Sex Days Min. January 12, 1 🔀 M 2 🗆 F 80 **Director** Maryland 218-28-4706 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🔀 No Anne Arundel Severn Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21144 751 Pine Road 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 🔀 Married 1 Yes If Yes, Give 2 XNo Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Defense 12 Cryptanalysis Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Loretta Mary Prather Mason H. Pennell 1 and 2 should bet Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia S. Booth/Wife Pine Road, Severn, Maryland 21144 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott west Arundel 1 🗆 Burial 2 😾 Cremation 3 🗀 Removal from State 8, 4 Donation 5 Other (Specify) Odenton, Maryland Crematory 21. Signature of Funeral Service Licenses 22 Name and Address of Funeral Home & Crematory, 1411 Annapolis Road, Odenton, Maryland 21113 MO1386 23a. Part 1. Enter the shock, or hear Enter the disease, or o , or head failure. List on implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between one cause on each line Onset and Death Immediate Cause (Final Physician/ Metastatic Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 2 YRS. Coronary Artery Disease Sequentially list conditions, cause. Enter Underlying Exami and -transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a detached f 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, icate has been sig 7, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate ! 1 Yes 2 No 1 Yes 2 V No Be 25. Was case referred to medical 26. Place of Death (Check only one) director, Hospital Other: 2K No မ 1 Yes 1 Inpatient 2 x ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this c funeral din 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending within 24 hours after death. To the Funeral Director: Al сотріете filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b 29c. License number 29d. Date signed (Month, Day, Year) ρ ooma W MA D0054739 June 7, 2011

State

Registrar

7845 Oakwood Road, Suite 204, Glen Burnie, Maryland 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Donna M. Eversley,

Date filed (Month, Day,

JUN 1 4 2011

M.D.,

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Prakash Rasiklal Pande 109AM Medical 20 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ,Tal ed a mose Sa 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days Hours Min. 09-28-1954 Country Director 135-13-5904 56 Usual Residence of Decedent "natural", or items 23a or 28a-f show die M Examiner must be notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 K No MD Nottingham Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 Whitelaw Place Apt. 21236 Kenya 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 Never Married 2 X Married Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examil Baltimore, Maryland 21215-0036 1 Yes 2 X No 3 Divorced Specify Completed South Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self - Employed Spare Car Parts Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rashiklal Chimanlal Pande Lilavanti Bhoiak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Krishma Vij / Daughter 8780 Little Neck Parkway Floral Park, NY 11001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o once, ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) W. Arundel Crematory 06-11-2011 Odenton, Maryland 21. Signature Funeral Service Lice 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effoct, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physiciani Ma ocasd Medical resulting in death) Due to r as a consequence of) Examiner 200000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Year Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate performed 1 Yes 2 No Yes the Hóspital or Attending Physician: ihin 24 hours after death.
the Funeral Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: ဂ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manney of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes Accident Investigation 2 No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and one to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and one to the cause(s) and manner as stated. (Check only one 29b. Signature and 29d. Date signed (Nonth, Day, Year) 30. Name and address who completed cause of death (Item 23a) (Type, Print) Franklin 000 31. Date filed (Month, Day, State 32. Registrar's Signature arko Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day POLAKOFF JUHE 0500 Medical JUHE 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard . Social Security Number 7. Age (In yrs. last birthday)
78 Yrs. **Funeral** 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Birthpia Country) 579-38-5507 1 🗆 M 2X🗆 F Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tien 27 is an Mertal Hygiene. Important: If tien 27 is an exted other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Columbia Howard 1 X Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 Funeral 10067 Windstream Drive Apt.2 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married þ Specify. White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname)
Josephine Robinson ೭ Edgar James Kesley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Polakoff/Spouse 10067 Windstream Dr. Apt.2, Columbia, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey crem. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 6/13/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD Marshall 21203 Pall 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner INFECTION URINARY IRACT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Dusity for as a consequence on that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Vear Pregnant at time of death 5 Other (specify) Day been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No 1 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No ပ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No thours after death uneral Director: A ed filled in by the fi 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination of the basis of examination of the basis of my knowledge. On A Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 70598 JUNE 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 CEDAR LANE, COLUMBIA AKHTAR CHOUDHURY: 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

4

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Shirley Patterson June 2011 10:23 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year __ If Under 24 Hrs. 8. Date of Birth **Funeral** 6 Year) 1 <u>922</u> (Month, Day Ye 1 □ M 2 🕅 F Months Days Hours Min. Illinois 88 Director 327-20-5333 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits Director MD Montgomery Bethesda 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6705 Pemberton St. 20817 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Armed Forces?

1 Yes 2XXNo Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: White If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Civil Worker Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hulda Braese Andrew Dobos permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bradley H. Patterson / Husband 6705 Pemberton St., Bethesda, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 XCremation 3 ☐ Removal from State 06/13/2011 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD Rapp Funeral and Cremation Services M00382 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ CARDIOPULMONARY ARREST disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 2-3 DAYS DEHYDRATION Sequentially list conditions Physician/Medical Examine Directo for es a nonsecuence off cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last YEARS ATRIAL FIBRILLATION Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2XXNc 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ី No မ 1 Inpatient 2 XER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending s after death. 2 Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Name Fractioner to the search my income dath commendation (income and the cause) and manner on stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JUAE 10, 2011. Margues 026449 OV e and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

BARRY TALESNICK M.D.,

31. Date filed (Month, Day, Year)

Patterson

5454 WISCONSIN AVE. #925,

CHEVY CHASE, MD

20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Brandi Lynn Phillips 2011 June 5:05 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **TOWSON** Examiner Baltimore Gilchrist Hospice Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Days Hours Feb. 16'e ^{ear)}1973 504-92-2434 38 California Director Usual Residence of Decedent 28a-f show 10b. Count at 10a State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Baltimore Baltimore Medical Examiner must be notified Maryland tXXYes 2 ☐ No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States 23a Funeral 21218 3924 Ednor Road of America death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o. à 1 Never Married 2 Married Maryland 21215-0036 be filed within 72 hours after If Yes, Give Year or Dates white 1 ☐ Yes 2X No Specify "natural", Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. d other than " went, the Mer College (1-4 or 5+) 5+ life. DO NOT use retired) Elementary/Seconday (0-12) 12 Law Lawyer event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve once. ပ္ Trude Sinning unk. Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7336 Iron Bit Dr. Warrenton, Virginia 20186 Trude Steele/ mother Baltimore, Date 3, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Evans Funeral June 1 Burial 2 X Cremation 3 Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland - Bel Air Chape] permit. 21. Signature of Frineral Service Licens Peaceful Alternatives Funeral and Cremation Ctr., P. .. Timonium, Maryland 21093 2325 York Road 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Buchs Metastanic Saycom disease or condition 12113 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur completed filled in by the funeral director, page 2 should be detached for use as the bur of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the f P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Deather (Specify) HVS FIC 1 ☐ Yes 2 ☐ No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Matural 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined cal 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: Tente sest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 10070635 6/11/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harles St Suite 405 Baltmane No Par 701 alva 31. Date filed (Month, Day, egistrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Steve Randazzo 20:35 June 8, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1134 Dorchester Avenue Gwynn Oak Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Months Days Hours 1 ☑ M 2 ☐ F **Director** 217-50-7717 62 May 20, 1949 Sicily Usual Residence of Decedent Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic events." 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 1 No Maryland Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1134 Dorchester Avenue 21207 USA Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White \$ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Auto Driver Varsity Auto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adamo Randazzo Carmela Difatta ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecelia Grimm Daughter 20 Turnberry Court; Monroe, NY 10950 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State n Cemetery 6-13-2011 Woodlawn , Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 21. Signature of Funeral Service Licensee Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville MOIOSD MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MABET YRS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. i any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): be executed attending physician and for use as the burial-transit PIDEMIA Yps Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 | Ectopic pregnancy Day Month Year 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached for ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ∐ Yes 2 🔀 No 1 🗌 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Division the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

RABINA MALIK

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEDICAL DOCTOR

D0063501

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 25 Day 2011 JANIE RICHARDSON 7:00 A M May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S FORT WASHINGTON HEALTH & FORT WASHINGTON REHAB Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X Months Hours JANUARY 13 90 578-26-0138 SUMTER Director 1921 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director 28a-1 MD PRINCE GEORGE'S FORT WASHINGTON 1X Yes 2 No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 23a Funeral 12021 LIVINGSTON ROAD 20744 USA items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner ō þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify. "natura!" Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) DOMESTIC PRIVATE other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MANIE ENGLISH MARION ENGLISH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE R. FOWLER - DAUGHTER 3503 MANIS ROAD, CLINTON, MARYLAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 😾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 06/02/2011 SUITLAND, MARYLAND LINCOLN MEMORIAL Signature of Famer Service Licensee 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME KENNEDY STREET, NW, WASHINGTON, MARYLAND 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter ode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final Physician/ disease or condition resulting in death) Medica Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) 2 🗌 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, cate has been si 1 Yes 2 🗹 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Yes 2 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical Be 26. Place of Desh (Check only one) examiner? 2 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this funeral 27. Manuer of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending work? V Natural injury Accident Investigation completed filled in by the 3 Suiciae 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical

State Registrar

29a. Certifier

(Check only one 29b. Signature a

31. Date filed (Month, Day, Year)

ne and address of person who completed cause of death (Item 23a) (Type, Frint)

32. Registrar's Signature

SYAN CU

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d, Date signed (Month, Day, Year)

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ RATAJCZAK 05:26 M 2011 KICHARD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ROCKVILLE SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F (Month, Day, Year, 030-28-7080 1938 Director 72 Massachusetts July Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Montgomery Village 1 ¥ Yes 2 □ No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19425 Brassie Place #201 20886 United States 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Man County Government Be Maryland permit. Page 1 and 2 should be filed. Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (Unknown) (Unknown) 19a. Informant's Name/Relationship (Type, Print) 20886 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Ratajczak / Wife 19425 Brassie Place #201, Montgomery Village, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 06/13/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD mcc382 Rapp Funeral and Cremation 933 Gist Ave., Silver Sprin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20910 Approximate Interval Between Onset and Death Immediate Cause (Final f nysician/ Pseudomona week disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş clostridium Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 certificate 1 Yes 2 No 1 Yes after death.

Director: After this certific 25 Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 NInpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2
To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the May 28 2011 D38262 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Research Blud + 330 Rockville, MD 20850 mendhiratta mo

DHMH 17 Rev 7/2009

State Registrar Anur.ta

31. Date filed (Month, Day, Year)

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2401

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:15 PM 10 m 2011 Chester Stanco UNE /Medical 4c. County of Death 4a. Facility Name (If not institution 4b City, Town, or Location of Death **Examiner** Boltimore 10) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 □ F 220-22-8913 Director April 27,1929 Maryland 82 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f shov 1 ☐ Yes 2 ☑ No Director Catonsville Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 514 Rest Avenue permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hyglene, important; if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, Its Medical Exprises marked other. 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 1 Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 🖾 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Mechanic HVAC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Stanco Frances Angelina Nowak ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earlyn Stanco Wife 514 Rest Avenue; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Good Shepherd 6/14/2011 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature a Funeral Sarvice Licano 1630 Edmondson Avenue; Catonsville, 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CMDS /Medical Due to (or as a consequence of): Ibstructure Pulmonar Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse wence of): Examine within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit SCOR Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, NOND Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1No 1 ☐ Yes 1 Dipatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 1 ☐ Natural 2 ☐ Accident 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number 30. Name person who completed cause of death (Item 23a) (Type, Print) Coton Avenue, Bal Moval es MD 31. Date filed (Month, Day, Year) 32. Raher's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death ^{Day} 2011 Month **Physician** June 9, 5:30 A.M Mary Catherine Schulz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 2411 Harborwood Road Catonsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1919 Maryland 212-01-6954 12, Director Jan. Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygene.
Instit If item 27 is marked other than "natural", or items 23a or 28a-f shown in 19 from other traumatic event, its "house it is an in a for natified. 1 ☐ Yes 2X No Director MD **Baltimore** Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 2411 Harborwood Road 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: þ 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Peters Catherine Meushaw ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Keil Manor Court; White Hall, MD 21161 Son Earle M. Schulz, Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. Loudon Park Cemetery | 6/13/2011 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner 6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (oras a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No certificate 1 ☐Yes 2 ☐No ours after death.

leral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. Mapper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicai Examiner: Mn he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

within 2 the

29b. Signature an

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

sarke

29c. License number

29d. Date signed (Month, Day, Year)

LIK 103 CAMPILLE NO 21128

and manner stated.

d cause of death (Item 23a) (Type, Priht)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 20a, b, perFH, G916, 6/21/2011, WS
State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month all. 11:06PM James Medical 4c. County of Death **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Bathmore Age (In yrs. last birthday) 77 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Mora 3 av 19 1 **№** M 2 🗆 F Months Hours Min. Director Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director Himore Yes 2 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral Ellamont S 21216 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 **∑** o Specify: Specify:  $\mathcal{B}$ lac 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) )river Be 17. Father's Name (First, Middle, Last) UNK Mother's Name (First, Middle, Maiden ဂ္ ce a ra bnes 19a. Informant's Name/Relationship (Type, Print) dral Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number of MD llamont Baltimore, 20a. Method of Disposition → ↑ ↓ ↑ ↑ 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of JAK) Date 20c. Location - City or Town, State cemetery, crematory or other place Baltimore, mo 4 Donation 5 Other (Specify) Green Mount 6/17/11 22. Naugher of Bein Greene fuseral Services 21. Signature of Funeral Service Licensee Ba Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Ventra disease or condition Medical resulting in death) **Examiner** authorosclante Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed hypatensio, and-trans Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 
Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Yea Day 5 Other (specify) 1 Yes 2 9 Unknown 2 🗆 No the Division of Vital Records, P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown icate has been signated to page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 PER/Outpatient 3 IDOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 00066240 Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Secous Hospital 2000. W. Baltimore Strat Baltimore MD Maraa Cort I mD Bon 31. Date filed (Month, Day, Year) 32. Projetrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret N. Sears June 6, 2011 6:15 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5914 Melville Road Eldersburg Carroll Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Jan . 4 Year 918 1 - M 2 X F 93 Maryland Director 213-05-3101 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Eldersburg 1 🗆 Yes 2 🔀 No MD Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21784 5914 Melville Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pittsburgh Elementary/Seconday (0-12) College (1-4 or 5+) the Plate Glass Assembly Line Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Minnie Semmont Charles E. Miller 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Sears-Son 5914 Melville Road, Eldersburg Maryland 21784 permit. Page 1 and 2 Department of Healtl Important: If item 2 any injury or other t Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Nemoval from State 4 Donation 5 Other (Specify)
Signature of turn all service Lines a Loudon Park Cemetery June 10,2011 Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed after death. Due to (or as a consequence of): resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Year Day 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy death? performed 1 ☐ Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1/Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) W.D D 33681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PROGRESS WAY SWITE 114 21784

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend#10b,10d,16b,18perfn g916,6-21-11 do State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Ronald Smith June 12:00th Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1236 Violette Ave. Baltimore City 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sept. 13, If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 ₹ M 2 □ F 214-62-3605 **Director** 58 Yrs Maryland 1952 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No Maryland Baltimore City 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1236 Violette Ave. 21229 United States 12. Was Decedent Ever in U.S.
Argued Forces?

1 Yes 2 No 1976
If Yes, Give 1978 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Completed Specify: White 3 Widowed 4 Divorced 1978 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) N/A Elementary/Seconday (0-12) Machinist Northrop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Livinia Auinia Milam John William Smith Milam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sk Department of Health a Important: If item 27 is any injury or other tra Katie J. Smith/ Daughter 1236 Violette Ave., Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Loudon Park Cemetery June 13,201 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring RD., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death emcnth shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Meta disease or condition resulting in death) Medical Examine Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last physician and the burial-transit Due to (or as a consequence of) Physician/Medical death certificate be Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached fi 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 ☐ Yes 2 ☐ No Yes 2 N director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division within 24 hours after death, To the Funeral Director Al completed filles in by the fu ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: T. the basis of my knowledge due to counse at the time, date and place, and our to the cause(s) and manner stated. (Check only on diet the time, determed place, and due to the e 29b. Signature and title of certifier 29c. License number 0 D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BALTIMORE MD 21229 y, Year) State Registrar

DHMH 17 Rev 7/2009

			For State		State of	Maryland		artmen tificate			and N	lental Hy	_	001	•	10706
			Registrar  1. Decedent's Nam	e (First, Middle, L	ast)		Cer	incate	- 01 D	eaur		2. Date of De	Reg. N	lo. /	-	3 Time of Death
	Physicia Medic		Maria	n Audr	ey Sheeha	an						June 9	, 20	Ö11 Y	ear	9:40 AM
	Examir	ier		Facility Name (if not institution, give street and number)						4b. City, Town, or Location of Death					Death	
-			Stell 5. Social Security N		Hospice 7.	Age (In yrs. last	hirthdayl	Timonium  If Under 1 Year   If Under 24 Hrs.			8. Date of Birth		Balt	D: 11		
	Funeral Director		479-09-9028			6 Yrs.	Months	Days	Hours	Min.	April 24		1915 Country Ic		try) Iowa	
	and show dat	١	Usual Residence of 10a. State	Decedent 10b. County		10c. City, T	own or Loc	ation						-	-	0d. Inside City Limits
	arylar ka-fsk ified a	Funeral Director	MD		imore		noniur									1 ☐ Yes 2 🗓 No
	the M or 28 e not		10e. Street and Nur					10f. Zip	Code				10g. C	Citizen of Wha	at Cour	ntry?
	s 23a	era	2525 Pc	t Spring	g Road, Un	n <b>it</b> L310	)		210	93				USA		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Mari 3 🏿 Widowed	ied 2 ☐ Married	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? X	If	Vas Deced Yes, spec	ify Cuban	, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Black, Specify:	White,	
5-0	hour "natu	plet	(Spe	15. Decedent's	Education grade completed)	1	16a. Deced	ent's Usua	l Occupa	tion	t of work	ina	16b.	Kind of Busin	ness Inc	dustry
121	thin 7% ene. than '	Completed	Elementary/Sec 12		College (1-4 N/A	or 5+)	life. DO	omema	retired)	ang mos	it of work	, ig		0	rm 1	Home
d 2	ed wir Hygie other ent, tł	Be (	17. Father's Name	First, Middle, Las	<u> </u>		п	Jillellia	Kei	18. Moth	er's Nam	e (First, Middle,	Maider		WII	nome
/an	d be fil dental rrked tic ev	유	Gerhard	t A. Lie	eb						_			e Sauer		
any	shoutch and N is ma		19a. Informant's N	ame/Relationship	(Type, Print)		19b. Mailin	g Address	(Street ar	nd Numbe	er or Rura	al Route Numbe	er, City o	or Town, Stat	e, Zip C	Code)
2 0	and 2 fealth sm 27 her tr				n/Daughter					<u>i11  </u>		, Cocke	_			
Baltimore,	t. Page 1 ar tment of He tant: If iter ijury or oth				Removal from St	tate Dula Men	e of Dispos etery, crem ney v noria	alle L Gar	her place dens	)		Pate 13,	Tí	Location - Ci imoniu	m, l	MD
Bal	permil Depar Impor any in		21. Signature of Fu	neral Service Lice	Michael	J. Flag	31e 22	Name and emmo	Address n Fu Pade	of Facility nera. onia	l Hor Road	ne of D i Timo	ular niur	ney Va n, MD	11e 21	y, Inc. 093
	Physician/ Medical Examiner	_		rt failure. List onl Final on	Cl.		ES CA		e of dying	, such as	cardiac d	or respiratory a	rrest,		+	Approximate Interval Between Onset and Death
	ite be executed hysician and he burial-transit	dical Examiner	if any, leading to in cause (Disease or that initiated event resulting in death)	nmediate rhyling iinjury s	c	as a consequent									.574	
760	cate by phys	edic			d											
. Box 687	e death certificate be executed the attending physician and thed for use as the burial-transi	Completed by Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 ☐ Live Bir 4 ☐ Pregna	3 ☐ Ectopic pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown								23d. Date of Month		ery Day Year
P.0	v requires that the de s been signed by the should be detached	by Pt	Part II. Other signi	icant conditions	s contributing to dea	th but not resulti	ng in the u	nderlying c	ause give	en in Part	l.					ne cause of death?
rds	equire	eted					_					1 🗆		/		bably 4 Unknown
Division of Vital Records,	has he 2											24a. Was auto perfe 1 \(\supersetarrow\) Yes	psy ormed?	dea	ath?	psy findings available mpletion of cause of
ital	nysician: The nis certificate director, pag	Be	25. Was case referr examiner? 1 ☐ Yes 2	ed to medical  No	Hospital:				Other			k only one)		1000		
of V	ding Phys h. After this funeral di	e: To	27. Manner of Deat	=	28a. Date of	patient 2 ER injury 28	b. Time of		Bc. Injury	at		me 5 LResi 28d. Describe			Specify	HOSPICE
ouc	tending death. tor: Afte the fun	icat	1 X Natural 2 Accident	5 Pending Investigat	tion	Day, Year)	injury	М	work?	res 2 🗆	No			,		
Divisio	or A fter lired n by	l Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could no determine	28e. Place of	Injury - At home , etc. (Specify)	, farm, stre	et, factory,	, office			28f. Location ( City or To			or Rural	Route Number,
2)	To the Hospital of within 24 hours a To the Funeral D completed filled i	Medical		Medical Exa	hysician: To the bes miner: On the basis urse Practioner: To	of examination ar	nd/or invest	igation, in n	ny opinior	n, death of	ccurred at	the time, date	and plac	ce, and due to	the ca	use(s) and manner stated
	To t with		29b. Signature and	the of certifier	es an	P		29c.	RICE License	number 44	192		29d. D	ate signed (	Nonth, 1	Day, Year)
K	1		30. Name and addr	JONES,	crnp 230	of death (Item 23			RD.	TTM	ONTI	M,MD 2	1093	7 -		
	Sta		31. Date filed (Mont	h. Day Yearl	32 Re	strar's Signature			10.	4.44						
	Registr	ar		JUN 14	2011	ma ,	1.	alle	/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11-04250 Jas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jason A. Shupe	1- For State Registrar	State	of Maryland /	Departmen Certificate			Menta	al Hyg		eg. No.	01	1 1879
Physician/ Medical Examiner	1. Decedent's Name	e (First, Middle,Lest) son Avery							Date of Dea Month June 6, 20	th Day	/ear	3. Time of Death 0700 hrs
		if not institution, give lemorial Hospita			- 1	City, Town, or L rederick	ocation of	Death		4c. Coun Frede	ty of Death rick	
Funeral Director	216-98 <del>-8</del>	295 1295	7. Age	ge (In yrs. last birthday)  29 Yrs.  If Under 1 Year If Under 24Hrs  Months Days Hours Min.					1Foreign			
Tow any	Usual Residence of 10a. State	f Decedent 10b. County Carre	i	10c. City, Town or I	Location Air	v						10d. Inside City Limits 1 Yes 2 No
uth the Maryland 23a or 28a-f show notified at once. al Director	10e. Street and Nur					of. Zip Code	1		1	0g. Citizen of		
r death with , or items 23 r must be no Funeral	_	ed 2 X Married		X No	If Yes,	ecedent of Hisp specify Cuban, I	Mexican, I				hite, etc.	ican Indian, Black,
2 hours after "natural"; "Examine:	3 Widowed 15. Decedent's Ed		If Yes, Give Year or Dates: ly highest grade comp College (1-4 or 5	pleted) 16a. Dec	cedent's l	s 2 X No  Jsual Occupation of working life. [	on (Give ki			Specification 16b. Kind of		nite
21215-0036 Muld be filed within 72 hours at Mental Hygiene, marked other than "natural c event, the Medical Examin	10 17. Father's Name			·	Body		8.Mother's	Name (F	irst, Middle, I	Auto Maiden Surna		Repair
2121! hould be fill hould be fill is marked it cvent, f	19a. Informant's Na	Shupe ame/Relationship (Ty	· .	I		Idress (Street		er or Ru		nber, City or T		
ore, MD ss 1 and 2 sho of Health and If item 27 is ber fraumati	Jennifer  20a. Method of Disp  1 x xBurial 2	position	(Wife)  Removal from Sta	20b. Place of D	7845 East Hill Place of Disposition (Name of ceme crematory from place) Tringfield				Mt. Airy, Maryl Date 20c Location -			
Baltimore, permit. Pages I an Department of Hes Important: If ite	4 Donation 5 Other Specify: Cemetery 6-10-2011 Sykesvil 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Witzke Funeral Hom										Homes	s, Inc.
Physician //Medical	23a. Part I. Enter th failure, List on	ly one cause on eac										21045 Approximate Interval Between Onset and
ixaminer	Immediate Cause ( or condition resulting Sequentially list con	ng in death) [	Cardiac tampona Due to (or as a conse Ruptured aortic (	quence of):								Death
ted	if any, leading to immediate couse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):											
60, e be executed ysician and burial - transit	UNPENDED	d	AMENDED 5 P	er fh g9	16 6	-17-11	vt					
). Box 68760, the death certificate by the attending physiched for use as the burn Physician/Mec										y Day Year		
cords, P.O. Box law requires that the deatl has been signed by the att 2 should be detached for ppleted by Physi	Part II. Other signi	ficant conditions	contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stafter death.  La Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in the funeral or Be Completed by Pertification: To Be Completed by P								—	24a. Was autop perfo 1 Yes	med?		utopsy findings available completion of cause of es 2 No
Vital hysician: this certif I director,	25. Was case referrence examiner?	Ho	ospital: 1 Inpatier	nt 2 🗸 ER/Outpa	atient 3	26.Place o	Mhas -	-		Residence 6	6 Othe	-
Division of Vital Rec pital or Attending Physician: The I ours after death. seral Director: After this certificate I filled in by the funeral director, page Certification: To Be Com	1 Yes  27. Manner of Deat  1 Natural  2 Accident	5 Pending	28a. Date of Injur (Month, Day,Ye	y 28b. Tim	e of Injur	y 28c. Injury		28		how injury occ		
FFEMALE: 23b. Was decodent pregnant in the past 12 months?   1												
											ne cause(s)	
• 132W	LaCo	un				O.C.M				June 7, 2		nth, Day, Year)
State	Zabiullah Al	i, M.D. Assis	tant Medical Ex	aminer 900 \	W. Balt	imore Stree	et, Baltin	nore, M	1D 21223			
Registrar  DHMH 17 Rev 1/2001 OCME 2006		4.00	neva B.	- 23	INAL							OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G916 6/14/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 07° Physician/ JUNE 2011 R. STREET 5:45 A Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** HARFORD FOREST HILL FOREST HILL HEALTH & REHAB CENTER 9. Birthplace (State or Foreign Country) Snow Hill Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex . Age (In vrs. last birthday) **Funeral** Jan. 06, 1919 Days Hours 1 □ M 2 🗶 F 92 Director 152-30-2693 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 No Rising Sun Maryland Cecil 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21911 U.S.A. 5 Pauge Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🔀 No If Yes, Give Specify: White 3X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic avent." College (1-4 or 5+) 5+ Elementary/Seconday (0-12) School Teacher Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Bruce Powell Lena Pusey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 210 Huff Ave. Paulsboro, NJ 08066 Mr. David Street 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of June 10, Br. Centery William C. Poyle Vet. Man. Cenetery 1 🗆 Burial 2 🗆 Cremation 3 🔀 Removal from State Wrightstown, NJ 2011 4 Donation 5 Other (Specify) Signati uneral Service Licensee Evans Fureral Chapel & Cremetion Services - I 3 Newport Drive, Forest Hill, Maryland 21050 Jeffrey Testerman (M01543)23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician end sta disease or condition resulting in death) Due to (or as a conse sence of) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Dav Pregnant at time of death 2 No Yes 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.8 autopsy performed' 2 🗆 No Yes 2 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: A Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury Natural 5 Pending Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number F sur 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V 615 W. MACPHAIL ROAD BEL AIR, MD. 21014 31. Date filed (Month, Day, Year) State barks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26taRe of Warhand 996 at ment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2011 Kathleen M. Siuta 11:15 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth (Month, Day, July 17 Funeral Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours 1 - M 2 XF 1942 177-34-6374 Director 68 Usual Residence of Deceden 28a-f show 10c. City, Town or Location 10a, State 10d. Inside City Limits with the Maryland Director must be notified MD. Baltimore Cockeysville 1 Yes 2 X No 10e. Street and Number 9 10f. Zip Code 10g, Citizen of What Country? er than "natural", or items 23a the Medical Examiner must be Funeral 21030 USA 9 Deer Pass Court Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 2 1 Never Married 2 X Married ☐ Yes 2 🙀 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kathleen Fuller James J. Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Stanley S. Siuta/ Husband 9 Deer Pass Court Cockeysville, MD. 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State 6-16-11 4 Donation 5 Other (Specify) Hilltop Service Co. Towson, MD. 21. Signature of Juneral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Due to (or as a nsequence of) Comoer disease or condition Medical resulting in death) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mo Month Day Pregnant at time of death Other (specify) signed by the a Yes 2 No 1 ☐ Yes ∠ □ 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death?

1 Yes 2 No certificate Yes 2 No within 24 hours after death.

To the Funeral Director; After this certifics completed filled in by the funeral director; To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6XXOther (Specify) Hospice 28a. Date of injury (Month, Day, Year) 27. Manner of ath 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Hatural 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0070635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Sate 4105 Bultimore, no 21204 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June June 11 2011 4:55 Merle E. Smith ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore 4701 Mawani Road Social Security Number g. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth Apr 1⁹/₂ 6. Sex **Funeral** 7. Age (In yrs. last birthday) 1 🗆 M 2 💢 F Months Hours °°1919 92 215-03-3333 Yrs Director Usual Residence of Decedent ems 23a or 28a-f show r must be notified at 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 🗌 Yes 2 🔯 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4701 Mawani Road 21206 USA items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Specify: Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Shop Worker Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clarence A. Fifer Emma Drommelhausen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy J. Winterbottom/ niece 651 Shore Drive; Joppa MD 21085 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 6/15/2011 Pikesville, MD Signature of Funeral Service L 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Towson, MD 21204 Inc. 23a. Part 1. Enter/the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on a ch line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Pmysician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-transi attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year signed by the a 1 ☐ Yes 24 g ☐ Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 To the Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably Unknown page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perfo certificate I within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one, examiner? Hospital 21 Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 27. Marmer of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at injury 5 Pending work?
1 Yes Accident
Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

21092

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Menth 31/1^D Physician/ 0507 SAYDEE SAMUEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GEORGE'S PRINCE LAUREL LAUREL REGIONAL HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) Social Security Number 6. Sex 1 ★ M 2 □ I 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days unk TRERTA 79 Yrs. Director /15 /1931 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 XYes 2 ☐ No HOWARD COLUMBIA MD 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? Funeral LIBERIAN 21044 5591 CEDAR LANE within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, by 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MECHANICAL ENGINEER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANNIE SAYDEE PETER SAYDEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing 5 5 9 1 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 91 CEDAR LANE COLUMBIA, MD. 21044 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau UGENE WAH/SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) OF HEAVEN 6/11/11 SILVER SPRING 21. Sign ture of Funeral Ser 22. Name and Address of Facility CAPITOL MORTUARY MARYLAND AVE 20002 23a. Part 1. Enter the disea or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. Interval Between Onset and Death Immediate Cause (Final Physician/ MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami that the death certificate be executed Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown g 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, or Attending Physician: The law requires DIABETES MELLITUS 1 Yes 2√2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION has autopsy performed? 1 ☐ Yes 2 😿 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 X No Other: မ MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death.

the Funeral Director: After in most of the funeral pleted filled in by the funeral properties. 1X Natural 5 Pending 1 Yes Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

DHMH 17 Rev 7/2009

within 2 To the comple

(Check

29b. Signature at

only one)

31, Date filed (Month, Day, Year)

JUN 1 4 2011

nun

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

32. Registrar's Signature

ack

BURGUIERS

7300 VAN DUSEN RD LAUREL.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

2966

MD 20707

0/

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 12, Physician/ 2011 12:56 PM Taylor Sharon Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Center for Hospice If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 M 2 XF Months 0172171947 218-46-6027 Maryland Yrs **Director** 64 Usual Residence of Decedent 28a-f show within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Baltimore Middle River 1 Yes 2 X No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be items 23a Funeral 3500 Wagon Trail Road 21220 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 'natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hyglene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Preston Cox Ann Mae Carter permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic t 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Debra Willick (Daughter) 9306 Good Spring Drive, Perry Hall, Md. 21128 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Oak Lawn Cemetery 06/16/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
Bestern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licensee 1 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ ling methstatic cancer di ease or condition esulting in death) mon Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami or Attending Physician; The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death ed by the detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 4 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 8 \( \text{Other (Specify)} \) \( \text{VSpn C } \( \text{C} \) 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 I DOA this I Director: After thi d in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier DO070635

Registrar

DHMH 17 Rev 7/2009

State

8417e 4105

Baltmore, MD

21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4701

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Churles St

32. Registrar's Signature

Pate

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

DHMH 17 Rev 1/2001

State

Registrar

4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bertha Mary Urie Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3611 Dahlia Lane Middle River . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
March 7, 1933 1 M 2 X F Director 212 30 5736 78 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at Director Baltimore Maryland Middle River 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? 23a 3611 Dahlia Lane 21220 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", Completed 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental | Charles Eckles Dorothy Heck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Robert Lee Urie Jr. 7134 Olivia Rd. Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite 2 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Bayview Crematory Inc. 6/14/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility
Bruzdzinski Funeral Home_P.A. 1407 Old Fastern Avenue Essex, Maryland 21221 23a/P/ n 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line Immediate Cause (Final Cardiopulmonary Arrest Physician/ Medical resulting in death) Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No
9 ☐ Unknown Pregnant at time of death signed by the at be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obstructive Records, 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? pertension autopsy 2 🛛 No Yes To the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work?
1 Yes 2 No s after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State, Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Cuithin 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Docell filed (Month, Day, Year) 32. Registrar's Signature

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yes 2 X No

Maryland

2011

Baltimore

Black, White, etc

Month

Day

1 Yes 2 No

Year

1:55 P M

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 9 201 I Year Physician/ Day HYMAN ULLMAN 7:35 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE PIKESVILLE ENVOY OF PIKESVILLE Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. 1 📉 M 2 🗆 F 96 217-38-6418 0 7/22/1914 Director NY Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director MD BALTIMORE OWINGS MILLS 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 USA 12100 RIDGE VALLEY DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces' Black, White, etc. 1 🗀 Never Married 2 🗆 Married ģ Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 XNo Specify: If Yes, Give 3X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha ATTORNEY LAW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 **JACOB** YUDOWITZ REBECCA SUROFF and 2 should be Health and Menta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau OWINGS MILLS, MD 21117 12100 RIDGE VALLEY DRIVE WILLIAM B. ULLMAN / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State OHEB SHALOM MEM.PARK 6/12/2011 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. roll PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD 23a. Part 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 Yes 2 No for Day Pregnant at time of death 1 Yes 2 9 Unknown s been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by law requires 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No. page 2 or Attending Physician: The 1 Yes 2 No Yes 25. Was case referred to medical Division of Vital Be funeral director. 26. Place of Death (Check only one) examiner? Hospital 2 Z No Other: 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending nours after death.

neral Director: Aff 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated сопріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 201 Name and address of person who completed cause of death (Item 23a) (Type, Print) umes 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ 2011 9. Robert Lee Wright June 11:16 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Dove House Westminster 8. Date of Birth (Month, Day, Yea May 14, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Hours 1**X** M 2 □ F Mary Land Months Director 215-40-2078 May 69 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2X No MD Carroll Westminster 0e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21158 2201 E. Mayberry Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces?
1X Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married δ 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 1962-68 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmin. Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare <u>Administrative Assistant</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Frederick Talbert Wright Grace Marie Grimes 19a. Informant's Name/Relationship (Type, Print), Domestic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James L. Knight/Partner 2201 E. Mayberry Road Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Final Journey Crematory 06/12/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licer coing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician/} disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician sthe burial Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No been signed by the should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 2 **N**o this certificate Yes 2 1 No 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🔲 Yes ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA nin 24 hours after death.

the Funeral Director: After thinpleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work' Μ 1 🗌 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and a on who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

4 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Kristen Renee D			State of M	aryland /					d Ment	al Hyg	iene	2		1980
	_	1- For State Registrar			Cer	tificate of	Deat	h		1.5		ı. No.		1 2 0
Physicia Medical Examin		1. Decedent's Name (First, M		D-11 r	7-1						Date of Death Month June 8, 201	Day Yea	r	3. Time of Death 0259 hrs
1		Kristen Renee			NOTCO		4b. City,	Town, or	Location of		Julie 6, 20	4c. County of	f Death	
1		Exit 39 Interstate 4	95 to River R	oad			Emery Corners					Montgon	nery	
Funeral		5. Social Securify Number	6. Sex 7. Age (In yrs			ast birthday)	If Und	er 1 Year		24Hrs. 8 Min.	3. Date of Birth	th(MM/DD/YYYY) 9. Bi Forei		1
Director		216-27-2942	1 M 2 X F 25			Yrs		is Days	Hours	WHIT.	Dec 18	, 1985 Cou		ntry)Maryland
any .	-	Usual Residence of Deceden 10a. State 10b. Cour		т	10c. City.	Town or Locat	ion							10d. Inside City Limits
				1	, ,									1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	Maryland Prin 10e. Street and Number	ice Geor	ge s i			10f. Zip	Code	ville		10	try?		
the M		3300 East Wes	st Hiahw	av #428	3			2078	32			United	Stat	es
h with	uneral	11. Marital Status	12. W	les Decedent f				ent of His	panic Origi		ify Yes or No-	14. Race	14. Race - American Indian, White, etc.	
r death	핊	1 Never Married 2 X	1	Yes 2	X No		If Yes, specify Cuban, Mexican, Puert			r derto rat	Jan, etc.)	1		1
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Division of Vital Rec To the Boptial or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate, completely filled in by the funeral director, page	Medical	(Check only one) 2 Medical I	Physician: To Examiner: On the	basis of exan	nination a	nd/or investiga	tion, in m	y opinion	, death occ	curred at the	ne time, date a	nd place, and o	ue to the	e cause(s)
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		in a	~ , ·	-				O.C.I	M.E.			June 8, 20	11	
W /	1	30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223												
0 V	212	Ling Li, MD Assi: 31. Date filed (Month, Day, Ye		32. Registrar			- Stre	et, Balt	imore, N	/IU 2122	دع			
Regist		11IN 1 4 2011	Beauce	1 1.		Red								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2011 Physician/ June 05, 09:49 A M Janet Friede Whiting Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Anne Arundel 1615 Earlham Avenue Crofton . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Min 1 🗆 M 2 🗶 F October 3, 1933 West Virginia 579-50-3035 **Director** 77 Yrs. Usual Residence of Decedent or 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Anne Arundel Crofton 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? be ms 23a must be Funeral United States 21114 1615 Earlham Avenue items filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 X No Black, White, etc "natural", or 1 Never Married 2 M Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Food Industry Home Economist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked or traumatic eve မ pe. Margaret Lewis Herbert Adolph Friede t. Page 1 and 2 should by treent of Health and Merchant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 Earlham Avenue, Crofton, Maryland 21114 Alan Wilmarth Whiting/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1
Department of I
Important: If it
any injury or ot West Arunde1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State June 7 4 ☐ Donation 5 ☐ Other (Specify) Crematory Odenton, Maryland 21. Signature of Funeral Service Licensee Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will El Dover M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events and as the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ for in the past 12 months? 1 ☐ Yes 2 🗓 No the detached Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be dei 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P. 2 Abdominal Aortic Aneurysm Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Obesity 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? Hypertension funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) miner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 X Yes 2 □ No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0025134 June 6, 2011 seepu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carol A. Pressey, M.D., 3168 Braverton Street, Suite 250, Edgewater, MD 21037

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

egistrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death WAGGONER Physician/ 201 Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year) 07/23/1920 If Under 1 Year Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🛛 F Months 90 **Director** 217-07-9392 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2X No Anne Arundel Glen Burnie MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21060 7355 East Furnace Branch Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Food / Beverage Waitress 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental မ Lottie Byron permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Charles Bosley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Glen Burnie, MD 698 Quail Drive Mrs. Patricia Schreiber / Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Toremation 3 Removal from State Glen Burnie, MD 4 Donation 5 Other (Specify) 06/13/2011 Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility 1 2nd Avenue SW Signature of Funeral Service Licensee Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Myocarcha hears disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as a consequence of signed by the attending physician and d be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Attract Fibrillation - Hapertentian Maporingian 23e. Did tobacco use contribute to the cause of death? Attial Fibrillation. Hypertention, Hyperhyloidism Cerebrovascular accident, coronary artery disease 1 Tes 2 No 3 Probably Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed has page 2 1 🗌 Yes 2 🗎 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at work? Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director; A 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certific June, 11, 20/1 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

Maswa Hegage 3001 South Hannover Street 2/25, Baltimore, 14D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 4 2011 Parks

Registrar

11-04298 Christopher Kier	an ∖			<b>or Print in B</b> l of Maryland						jible.		
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To wit	Mec	29b. Signature and		and manner stated.				nse number		29d. Date signed (M		
	O.C.M.E. June 8, 20											
101	Ì	30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223										
	لب	Ling Li, MD					Street, Ba	iltimore, M	D 21223			
St Regis		31. Date filed (Mon	UN 1 4 2	32 Augloka	s signatur	barr	2					
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DHMH 17 Rev 1/2001

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistrarAMEND#23bperMD,5/31/11;BMW,MoCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 4:10p M Martin Ammerman 2011 May 22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Arcola Nursing Home Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/29/1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 1**X** M 2□ F Days 182-09-3709 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hyglene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nutified at once. 1 ☐ Yes 2 No Director Bethesda Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code U.S.A. 20816 5401 Westbard Avenue, Apt. #1313 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No 1941 − If Yes, Give Year or Dates: 1943 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 2 Specify White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Baking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Rosenthal Harry Ammerman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5402 Center Street, Chevy Chase, Maryland 20815 Stuart Ammerman- Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 🔲 Rem Judean Memorial Grdns: 05/24/2011 | Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Fundral Servi 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (Sones Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Diebetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burlan-transit ettending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE TEMOVE item 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 PNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 1000 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 — ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and the time, date and place, and due to the cause(s)

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier indeep MO 00064624 5-23-2011

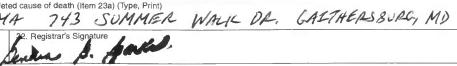
State Registrar

MAY 24 2011

SANDEED

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For AMEND#14 per FH State S/31/2011 AA CO Health Dept. CMH Certificate of Death 2. Date of Death 3. Time of Death Physician/ DEGOROYE 602 PM IRANLADE Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Upper Marlboro 2013 Hancock Dr. If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 1 ★M 2 ☐ F 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min Sept. 8 Year 950 Country Nigeria 60 Director 219-53-4131 Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Director 1 Yes 2 No Prince George's Upper Marlboro MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 -Nigeria 2013 Hancock Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ should be filed within and Mental Hygiene. Medical Practitioner Hospitals Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Comfort Adewunmi William Adegoroye 19a. Informant's Name/Relationship (Type, Print) Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Ileola Abimbola Adegoroye Upper Marlboro, MD 2013 Hancock Dr., 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State George Washington Cent 6/4/2011 Adelphi, MD 4 Donation 5 Other (Specify) 21. Si conure of theral Sen 22. Name and Address of Facility Beall Funeral Home Bowie, MD 6512 NW Crain Hwy., for 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ bladd disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) certificate be executed and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ast attending IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Vear Day Pregnant at time of death 2 No the 3 9 Unknown g Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy Hospital or Attending Physician: The 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: 1 🗌 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 💆 Natural injury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ^{Day}011 Ashe Gregory May 25, 3:05 p ^M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery_Co. Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) Funeral Min. 1X M 2 D F Director 213-52-9237 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 3a or 28a-f sh be notified a 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral Street, NE U.S.A. 20019 death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 filed within 72 hours after 2 No 1 Yes 2X No Specify: Specify: 3 Widowed 4 Divorced BLACK Completed 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled 12th Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Cherry Victoria Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 4238 Suitland Road, #101 Suitland, Maryland 20746 April Ashe - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Riverdale Park Crematory 5-28-11 Riverdale, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Home Signature of Funeral Service Licenses 10583 Middleport Lane, White Plains, Md. 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Cirrhosis disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or I that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Year Pregnant at time of death Unknown 9 Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be Chronic Kidney Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page death? Yes 2 X No 1 Yes 2 X No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 1 Tyes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, ð 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division s after death. Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0063195 May 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Wilks, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 31. Date filed (Month, Day, Year 32. Regist State Registrar

ASHE, 5

G-REGIORY

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records.

Division of Vital

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31. Date filed (Month, Pay, Year)

JUN 1 4 2011

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32. Registrar's Signature

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	_	For State Registrar					tificate of l			eg. No.		18816	
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Examin	er		not institution, given Medical	ve street and number) Center			4b. City, Town, o	r Location of Death			nty of Dear <b>shin</b> g		
Funeral		5. Social Security No	umber 6.			ast birthday)	If Under 1 Year Months Days		8. Date of Birth		9. Bir Co	thplace (State or Foreign	
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2 hours after death with the Maryland "natural", or items 23a or 28a-f show sdical Examiner must be notified at	ed by	3 K Widowed		If tes, Give Year or Dates.	1 反 Yes 2 ☐ No If Yes, Give 1 Year or Dates.			Specify:		Speci	^{ify:} Whi	te	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inopartment of Health and Mental Hygiene. The mater is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.				Removal from Stat	_ C	Place of Dispo	sition (Name of natory or other place g Cremate	ce)	Date	20c. Location	n - City or	Town, State	
Departme Departme Importar any injur		21. Signature of Fur		_		22	. Name and Addre	ess of Facility Re	st Haven	Funer	cal C	hape1	
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Physician/ Medical Examiner		23a. Part 1. Enter the shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List only Final	one cause <b>d</b> n each li	s a consequ	ser L	0-	ng, such as cardiac	or respiratory arre	st,		Approximate Interval Between Onset and Death	
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  b. Metawar Cause  Due to (or as a consequence of):  Aute muce Cause  Due to (or as a consequence of):											
(e) Hi Hi	cal	resulting in death) [	Last	d.	s a consequ	Jence on:							
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Luneral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burneral director.	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 r 1  Yes 2 9  Unknown	months?	23c. If yes, outcom 1  Live Birth 4  Pregnant 9  Unknowr	2 Feta at time of c	al death 3	Ectopic pregnand Other (specify)	су			Date of de Month	elivery Day Year	
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with Volume		29b. Signature and	title of certifier	- 2R,	prop.		29c. Licens	e number 02440	2	9d. Date sign 06/	ned (Monti	n, Day, Year) 911 M, MO21747	
11,24				completed cause of	death (Item	23a) (Type, F	Print)	^	ed 11	100011		× 11/47	
Stat Registra		31. Date filed (Month		Ca MO 32. Regis	rar's Signat	y Me	aical, (	ampis	ra. H	30.21	vw	TI, MIDO!	
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State of Maryland / Department of Health and Mental Hygiene 201 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05/20/2011 WILLIAM S. BUDD 0322 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 □ F Months Hours Min. (Month, Day, Year) 04/29/1943 Country) **Director** 215-44-3304 68 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Montgomery Kensington 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3000 McComas Avenue 20895 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: l Hygiene. other than "natural", Specify: 3 Widowed 4 Divorced Completed Black Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Caddy Master</u> Columbia Country Club Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental F ည Earl Budd Lydia Davis traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Michael J. Meyer/representative 12124 Chancery Station Circle, Reston, VA 20190 20a. Method of Disposition Place of Disposition (Name of 20c. Location - City or Town, State 1 M Bunal 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donal on 5 ☐ Other (Specify) etery, crematory or other place) 05/25/11 Memorial Cem Sandy Spring, MD Signature of Juneral Service Lice 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 o not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease ns that caused the death Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician/ EUMONI Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events physician and the burial-trans Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Yes 2 No should be detached 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed page 2 s has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, paragraphs. ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Other: ည 1 Inpatient 2 PER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 🗜 crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00057124 ano, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, MD 10110 Molecular Drive, #206, Rockville, MD 20850 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

altimore,

Box 68760

P.O.

Records,

**Division of Vital** 

			For State Registrar	State of Marylan		artment of H <i>rtificate of L</i>			iene	18818	
16	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Boyer				2. Date of Deat	29 2011	3. Time of Death	
8	Examin Funeral		Social Security Number 6. Sex	rstown 7. Age (In yrs.		4b. City, Town, or  Hage  If Under 1 Year  Months Days	Location of Death	1	4c. County of Death Washing		
	Director A +		216-05-6309  Usual Residence of Decedent  10a. State 10b. County	1M 2反F 91 10c. Cit	Yrs. ty, Town or Lo		Tiodis Willi.	March 26	, 1920 Mar	10d. Inside City Limits	
936	with the Maryl 3a or 28a-f sho t be notified a	Funeral Director	Maryland Washing 10e. Street and Number 122 Manor Drive, A		agerst	10f. Zip Code	21740	1	1 🙀		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Examiner must be notified at			12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No		pecify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	can Indian,	
21215-0036	be filed within 72 ho ntal Hygiene. nd other than "natu event, the Medical	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup e kind of work done o DO NOT use retired Homema	during most of wor 1)	rking	16b. Kind of Business/In	ŕ	
Maryland 2	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If Item 27 Is marked other t any injury or other traumatic event, th <u>once.</u>	To Be Co	17. Father's Name (First, Middle, Last) Walter Sherlin Cra	ampton	1	Homema	18. Mother's Nan	ne (First, Middle, M Virginia	Maiden Surname)	Onie	
			19a. Informant's Name/Relationship (Ty) Kay L. Dick/foster	r, City or Town, State, Zij	yland 21740						
Baltimore,			20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	emoval from State Mo	cemetery, cre untain	osition (Name of matory or other place  View Cem  2. Name and Address	. 06/	01/2011 5	20c. Location - City or T Sharpsburg, ffer Funera	Maryland	
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	cations that caused the deather cause on each line.  Due to (or as a consection).  Due to (or as a consection).	th. Do not en		ng, such as cardiad	or respiratory arre		ryland 2171 Approximate Interval Between Onset and Death	
,0928	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consect	quence of):			J		=	
.O. Box 6	the death certific / the attending p ched for use as f	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 0 9 □ Unknown	al death 3	□Ectopic pregnancy	/		23d. Date of deliving Month	very Day Year	
ords, P.	w requires that the de been signed by the s should be detached i	by	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the u	underlying cause giv	en in Part I.	23e. Did tol	bacco use contribute to es 2 No 3 Pro		
al Records,		Completed						24a. Was a autops perfori 1 Yes	sy prior to co	opsy findings available ompletion of cause of 2 No	
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		ont 2 DOA Oth	OF:	ath (Check only on			
O	<b>₽</b> ₽	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie	III 3 DOA	4 Nursing F		ence 6 Other (Spec ow injury occurred	ify)	
Division	i or Attending F after death. Director: After in by the funeri	Certification:	Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year)  28e. Place of injury - At h	Injury	M 1□	k?" Yes 2 □ No	28f. Location (S	treet and Number or Rui	ral Route Number,	
Ö	plta ours eral filled		29a. Certifier 1 Certifying Phys	sician: To the best of my kn- ner: On the basis of examin	owledge, dea	th occurred at the til	me, date and place	e, and due to the curred at the time.	cause(s) and manner as	stated.	
	To the Hos within 24 hc To the Fun completely	Medical	29b. Signature and title of certifier	and manner stated.	1 00	29c. Licens	e number		29d. Date signed (Month		
N	-4	ate	30. Name and address of person who co	ompleted cause of death (Itel  OCO (CI K.  32. R sistrar's Sign	CRUP		5748 ugh Pil	ce riag	cistour 1	1021742	

JW-4 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mon James Michael Boyd 1:45M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington County Hagerstown If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 72 Yrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Year) 9,1938 Min 184-30-0944 1 X M 2 □ F Pennsylvania Director Sep. Usual Residence of Decedent ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19115 Bonnie Briar Lane 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian rmed Forces?

X Yes 2
Yes, Give 1962 Black, White, etc. \$ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White 3 Widowed 4 Divorced Completed Year or Dates. 1965 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Crop Protection Specialist Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ James Boyd Lillian Byrd Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19115 Bonnie Briar Lane Hagerstown, MD 21742 Jane Boyd-wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1: Department of I Important: If its any injury or of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Smithsburg Crematory | 5-31-2011 Smithsburg, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Approximate Onset and Death Ph sician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy 3 in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown P.O. s been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records, Completed 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: To the Hospital or Attending Physician: The I within 24 hours after cleath.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page completed filled in by the funeral director, page perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate; 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) injury 1/ Natural 5 Pending 1 ☐ Yes 2 ☐ No Acciden Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 😿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JW-14+1 State Registrar

Dach my

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Physician/ Month Patricia Ann Bryant  $P^{M}$ May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 715 Cottonwood Drive Severna Park If Under 1 Year If Under 24 Hrs Social Security Number . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Country) Pennsylvania **Funeral** 1 M 2 12 F Director 178-32-2105 69 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severna Park 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21146 715 Cottonwood Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Completed by 1 Never Married 2 Married 1 Yes 2**X** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Midowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NSA Computer Science Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stephanie Lach Francis Klayko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 Grandin Ave., Severna Park, MD 21146 Willard E. Bryant/Son 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 05/23/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Metro Crematory 21. Signature Fun ral Service Lica see 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) ) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Yea Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been a completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗆 No Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifi 29c. License numbe 29d. Date signed (Month, Day, Year) 201 3 who completed cause of death (Item 23a) (Type, Print) Name and address of person 31. Date filed (Month, Day, Year)
MAY 25 2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Brown 1255AM helma /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Forestville Health & Rehab. Center District Heights Prince George's 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. 1 □ M 2 🕱 F Months Days Hours 94 30, 1916 Virginia Director 125-05-3034 Oct. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Evaminer must be notified at 1 X Yes 2 □ No Director Maryland Prince George's Capitol Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene. 7721 Beechnut Road 20743 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: Black ģ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Health and Mental Hygiene. em 27 is marked other than ther traumatic event, the M College (1-4or 5+) 12th Garment Worker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Fielder Jennie Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 Department of Health Important: If item 27 any Injury or other the once. Earl R. Anderson - Son 7721 Beechnut Road Capitol Heights, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salem Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State June 4 4 Donation 5 Dother (Specify) 201Î Salem, New Jersey Evergreen Cemetery 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral/Service Licenses 20019 (2 Washington, DC 4001 Benning Road NE Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, for your law to light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending physic for use as the b 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has be irector, page 2 sl autopsy perform 1 □Yes 2 □No 124 hours after death.

Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Funer completely fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State of Maryand Registrar #19 per FH 06/06/11 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dorothy Hebner Bloodsworth Day 2011 РМ 30 9:20 Mav Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sacred Heart Home Hyattsville Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Davs Hours Min. (Month, Day, 216-16-4391 88 **Director** Baltimore, December 8 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Hyattsville 1 🛛 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5805 Queens Chapel Road 20782 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. δ 1 Never Married 2 Married If Yes, Give WWII 1 ☐ Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Nurse other 1 4 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked ٥ William J. Hebner Mildred Tames 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural RWA SHIPM CIPONown, State, Zip Code) Stephen Bloodsworth / Son 3305 18th Street, N.W.; Wawhington; DC 20010 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State Metropolitan Crematory 6/1/2011 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial Infarction disease or condition Months Medical resulting in death) Due to (or as a consequence of) **Examiner** Arrhythmia 5 Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam death certificate be executed Chronic Obstructive Lung Disease Years and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Year 2 🛛 No the 9 Unknown g Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Osteoporosis Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Pelvic Cancer 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy Yes 2 X No 2 🗌 No 1 Yes Be 25. Was case referred to medical certifi 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending X Natural injury Accident 5 Pending s after death.

I Director: Af
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Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month CHIT TOPIANO E2 9.18 PM 201 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death Howard (serer wyth towar Lumsi 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 □ F Days Jan.25Months Hours Min Salvador **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Maryland Prince Georges Riverdale 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ral", or items 23a о Examiner must be Funeral with 5307 59th Avenue 20737 El Salvador Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 X Yes 2 No Specify: Salvadorian If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ 0 Miller and Lund Co. Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Benitez Sebastiana Paz Lazaro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5307 59th Ave. Riverdale, MD 20737 Maria L. Paz (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Piedras reBiancas place) 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 06/07/2011 La Union, El Salvador 21. Signature of uneral Solvice Licenses 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Distanty one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Physician/ O CUYC disease or condition resulting in death) Medical Examiner Due to s a consequence of BE Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury W15 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the caus 29a. Certifier (Check sis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Jurse Practione To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2011 26 ed cause of death (Item 23a) (Type, Print) 2104 CEDALLLANE State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY Month Physician/ 2011 9:05 PM EVELYN PEARL BEAR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S CENTREVILLE CORSICA HILLS NURSING HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours DEC. 5. 1 M 2 X F 96 1914 PENNSYLVANIA Director 188-09-9741 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2X No STEVENSVILLE MARYLAND QUEEN ANNE'S 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 106 FOX RUN LANE 21666 death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0036 within 72 hours after 1 Yes 2 XNo Specify Specify: WHITE 3X Widowed 4 ☐ Divorced Year or Dates 16a, Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ GEORGE W. BROWN PEARL PETERS traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rmit. Page 1 and 2 sh partment of Health a portant: If item 27 is y injury or other trai 106 FOX RUN LANE, STEVENSVILLE, MARYLAND, 21666 JUDY ANN MONGER/ DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of LANCASTER or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot MAY 26. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 MEMORIAL PARK PENNSYLVANIA Signature of Funeral Service License FEALLOWS AdMENTENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine and I-transit Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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e Funeral Director: A pleted filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one) 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State Registrar **Physician** /Medical

**Examiner** 

**Funeral** 

Director

Examiner

Physician/Medical

Be Completed by

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Medical Certification:

To Be Completed by Funeral Director

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1 Burial 2 4 Donation  21. Signature of Fu  23a. Part 1. Enter ti shock, or hear	Termation 3 5 ☐ Other (Special Service Lice)  The disease, or continue. List only Final	mplications that caused one cause on each lir	Fund 0433 I the death. I	Po not ente	Name and Ado	fal May dress of Facility Fa 902 Brace lying, such as cardi	3125 airf ddoc ac or res	Fax Me	airfax, emorial , Fairf	Vin	rginia			
disease or condition resulting in death)  Sequentially list conif any, leading to incause. Enter Under Cause (Disease or that initiated events resulting in death) in the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condit	nditions, imediate srlying injury	b. Bone to (or as Due to (or as Due to (or as CERE)	11.	ROU) ce of): VEN	Aplas	ÌA TROMBOZ								
IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2[ 9 ☐ Unknown	months?	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal de	ath 3	Ectopic pregna Other (specify)				23d. Date of Month	delivery Da	y Year			
Part II. Other signit	ficant conditions	contributing to death t	out not resultii	ng in the u	nderlying cause	given in Part I.		23e. Did toba	acco use contribut		. /			
							-	24a. Was an autopsy performe	ed? prior deat	to comp	r findings available sletion of cause of			
25. Was case referrexaminer? 1 \( \text{Yes} \) 2 \( \text{P} \)		Hospital:	ent 2 🗆 ER,	/Outpatient	t 3□DOA C	26. Place of De			ce 6 Other (S	Specify)				
27. Manner of Deat  1 Natural  2	5 Pending investigati 6 Could not determine	28a. Date of Inju (Month, Da	y Year) 28	Bb. Time of Injury	M 1	fork?	v injury occurred eet and Number o State)	injury occurred et and Number or Rural Route Number,						

To the Hospital or Attending Physician; The law requires that the death certificate be executed completely filled in by the funeral director, page 2 should be detached for use as the burial-transbeen signed by the attending physician To the Funeral Director: After this certificate has within 24 hours after death

**Physician** 

/Medical Examiner

> 25. Was c exami 27. Mann 1 2 A 4 🗆 H 29a. Certifier (check only 1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201

CHRISTIAN MEYER FREDERICK

600 North Wolfe St, Baltimore, MD, 21287

State Registrar 31. Date filed (Month, Day, Year) MAY 26 2011



11-04187 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Pieteraella Simone Bommelje 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Da June 3, 2011 **Medical Examiner** 1839 hrs Pieternella Simone Bommelje 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Anne Arundel 1724 Vineyard Trail Annapolis 9. Birthplace (State or Foreign Washington, Country) 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 6 Sev 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Davs 05/24/1973 Director 38 2^X F 217-19-9188 1 M Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 X No Maryland Anne Arundel Annapolis death with the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21401 1724 Vineyard Trail Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14 Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes Specify: White Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divorced ≦ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 Education Teacher 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gerda Adriana Bommelje Carleton Edward Schearer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 1724 Vineyard Trail, Annapolis, Maryland 21401 Gerda A. Bommelie/Mother ses I and it of Health a st. If item 2' 20a. Method of Disposition

1 Burial 2 T Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Kalas Crematory 06/10/2011 | Edgewater, Maryland Other Specify: 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Fungial Service Licenses 2973 Solomons Island Road, Edgewater, 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Modical Death Immediate Cause (Final disease a Seizure Disorder Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Ca AMENDED 23a, 27, per me, g918 8-11-11 sm X UNPENDED rttending physician or use as the burial Physician/Medi Box 68760, 23d Date of delivery IE EEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Year 2 Fetal death Month past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. \$ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has death? Dage Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) the Hospital or Attending Physician: director. Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene DOA this 1 Yes 28a. Date of Injury (Month, Day,Yeer 28b. Time of Injury 8c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: 1 X Natural Director: 5 Pending 1 Yes 2 No death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🔲 Could not be Suicide or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 4, 2011 O.C.M.E.

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

Pamela E. Southall, MD

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 10:18 P M May Vernon Robert Cooper, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Taney Avenue #203 1418 L. Frederick Frederick 8. Date of Birth (Month, Day, June 5, Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min. June Director 78 MD 218-30-2775 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🛛 Yes 2 🗌 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1418 L. Taney Avenue #203 21702 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 Black, White, etc. 1  $\square$  Never Married 2  $\square$  Married ğ Maryland 21215-0036 1 Yes 2 XNo Specify: 3 → Widowed 4 □ Divorced If Yes, Give Completed Black Year or Dates. 1953 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry 11 Truck Driver should be filed v and Mental Hyg ris marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Maudella Watson George W. Cooper or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Ave. #203,Frederick, MD 21702 Macey Mason/Daughter Taney Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Cemetery May 9,2011 Rockville, MD 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licenses 14th Street, NW, Washington, DC 20011 м00969 3821 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such secardiac of respiratory arrest, Approximate shock, or heart failure. List only one cause on each Interval Between heet and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed E that initiated events resulting in death) Last Due to (or as a consequence of) for use as the buria physician Physician/Medical Box 68760 the attending IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a 2 🗌 No g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Tyes 2 No 3 Probably 4 Unknown s been significant beautiful to should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k autopsy director, page 2 performe 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home Residence 6 C Other (Specify) completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 🗌 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print SON 31. Date filed (Month, Day, Year) State 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For A State Registrar Amend Item 1 Certificate of Death WCHD/TF 6/8/11 per FH Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mable Etta Criswell 8:59 a^M 2011 June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 7 East Washington Street, Apt. Washington Hagerstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Virginia Months Days Hours Min. June 12, Yea 59 **Director** 217-56-1930 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland must be notified at Director 28a-f 1 X Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 7 East Washington Street, Apt. 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian traumatic event, the Medical Examiner Black, White, etc. ō ģ 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry oe filed win. ⁴al Hygiene. ⁴ar than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Rehabilitation Center Support Services Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even once. 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edward Calvin Criswell Marjorie Annadean Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 East Main Street, Middletown, Maryland 21769 Kathleen E. Shankle/sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔲 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 06/03/2011 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike, Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequen of) Examiner Sequentially liet conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should ensin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy certificate | 2 **X** No I ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death Date of injury (Month, Day, Year) Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 5 Pending Natural Division 2 Accident
3 Suicide
4 Homicide Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) within 24 hours a

To the Funeral D Medical 29a. Certifier 🤆 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of not knowledge 29b. Signature title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 044996

Registrar

State

30. Name and address of person who

31. Date filed (Month, Day )

se of death (Item 23a) (Type, Print)

gistrar's Signature

11 Lappans Rd. Nonsbaro MD 21713

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person

Year)

31. Date filed (Month, Date

who completed cause of death (Item 23a) (Type, Print)

82. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene T = For State Registrar Reg. No Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 10:00P M Ellen Elizabeth Crawford 2011 Mav Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Nursing Home Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F July 27,1919 214-16-0864 91 Pennsylvania Director Usual Residence of Decedent 28a-f shov 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits the Maryland must be notified at Director Maryland Washington County Hagerstown 1 ☐ Yes 2 X No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral Page 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hyglene. and the fleet at 27 is marked other than "natural", or items 23a ant. If item 27 is marked other than "natural", or items 23u ury or other traumatic event, the Medical Examiner must b. 21742 12925 Cathedral Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Personal Residence Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Walter Smith Bessie Freeze Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7501 Mount Vista Rd. Kingsville, MD 21087 19a. Informant's Name/Relationship (Type, Print) Kaye Crawford-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 6-3-2011 Hagerstown, Maryland Rest Haven Cemetery ! 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the / isease, or come locations that caused the divath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear vailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final venmonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ig physician and as the burial-transit that initiated events I or Attending Physician: The law requires that the death certificate be executafted foath.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-tra resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? Dav Year 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 honknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 058570 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JW-5 MA 31. Date filed (Month) Day

State

Registrar

parke

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 18832 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 7:25 A May Physician/ LINUSOS CANTLER ESTER 4c. County of Death Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel Annapolis 468 Forest Beach Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Age (In yrs. last birthday) 5. Social Security Number 2/26/1935 Mary Land **Funeral** 218-36-5985 76 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10h County 28a-f shov ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 X No Annapolis Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA 21409 by Funeral 468 Forest Beach Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Black, White, etc. 11. Marital Status Armed Forces? 1 X Never Married 2 Married 1 🗆 Yes 2 🔀 No White Baltimore, Maryland 21215-0036 Year or Dates. Korea 3 Widowed 4 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Seafood Elementary/Seconday (0-12) Waterman 8th 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Elizabeth Laura Ritchie permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic even once. and Mental F Louis David Cantler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1731 Chesapeake Drive, Edgewater, Maryland 21037 Catherine S. Cantler/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 05/24/2011 | Edgewater, Maryland Kalas Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of June 18 Service Light See 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SHILM NA MELANOMA JALIGNANT Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examine the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23h Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death g Unknown the a g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ signed Completed by 1 Yes 2 No 3 Probably 4 Mnknown HYPERTENSION, HYPERLIPIDEMY 24b. Were autopsy findings available prior to completion of cause of peen 24a. Was an autopsy death? this certificate has 2 KNo 1 🗌 Yes Yes 2 XN 26. Place of Death (Check only one) 25. Was case referred to medical Be ( funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certificate: To 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 27 Manner of Death injury After Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5-23-11

3+ State

Registrar

31. Date filed (M MAY 25 2011 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

277 Peninsula Farm Road, Arnold, Maryland 21012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $2\overset{\text{Day}}{0}11$ 8:20 Henry Domenic Chieffo May 28 AMMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Landover Hills 6903 Barton Road 8. Date of Birth (Month, Day, **November** g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs, last birthday) **Funeral** Months Days Year) 11.1912 New York. Hours Min. 1 X M 2 D F 98 143-38-9514 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director Landover Hills 1 Yes 2 X No Maryland Prince George's 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 6903 Barton Road 20784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. 1 Never Married 2 Married þ X Yes 2 ☐ No Yes, Give T Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 🛮 Widowed 4 🗆 Divorced Specify: White WWTT Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Medical Doctor Cardiologist 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental Important: If item 27 is marked o Salvatore Chieffo Rachel Russo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6903 Barton Road, Landover Hills, MD 20784 Donna M. Ivy / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗵 Burial 2 🗆 Cremation 3 🗆 Removal from State 9 injury o 6/4/2011 North Arlington, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 on 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Aspiration Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or iinjury Advanced Age that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Impaired Gait 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Restrictive Lung Disease 24a. Was an has performed this certificate 1 Yes 2 No Yes 2 🗵 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) P 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at X Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

104,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schissler, 7500 Greenway Center Drive, Suite #430, Greenbelt, MD 20770

29b. Signature and title of certifie

DHMH 17 Rev 7/2009

State Registrar 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D22780

29d. Date signed (Month, Day, Year)

5/31/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 27^{ay} 2011 10:05 PM Mav Florence C. Cramer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Woodstock 2245 Merion Pond 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 1 M 2 XF Months Days Hours Min Oct 5, 1918 Yrs MD Director 215 03 7152 92 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director be notified 1 ☐ Yes 2 No Woodstock MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a United States 21163 **Examiner** must 2245 Merion Pond within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1. Marital Status Black White, etc. "natural", or ò 1 Never Married 2 Married 1 ☐ Yes 2 🎛 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) St. Agnes Hospital Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Antkowiak John Leonard Bauer 1 and 2 should b f Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2245 Merion Pond Woodstock, MD 21163 Evelyn Catherine Cramer/Daughter permit. Page 1 and Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 06/03/2011 | Baltimore, MD New Cathedral Cem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. Colle Thene 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final CARDIO Pul Physician/ MOINAR disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine sician and burial-transit Fibrillation The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 Xo Month Pregnant at time of death the detached Unknown 9 Unknown P.O. þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ALZHEIMER'S DEMENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed OSTED ARTHRITIS. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has page 2 perform death? 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2X No Other: 1 Tes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After XNatural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide M Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number 4 Homicide determined building, etc. (Specify) City or Town, State, Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certi 29d. Date signed (Month. Dav. Year) .30469 May 31, 2011 ted cause of death (Item 23a) (Type, Print) おちらっていしいれる(あ 100 PARTURY: + 3=8, Columba, MD Vellanki

State Registrar 31. Date filed (Monti

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Marylan				ealth a Death	ind M	lental Hyg	giene neg. No	We depress cons	18835			
	Physici		1. Decedent's Name (First, Middle, Las  An Ta Car								2. Date of Dea Month	Day	Year	3. Time of Death			
Sec. 15	/Medic Examin		4a. Facility Name (If not institution, give Charlestown		er)				Location o				nty of Death				
	Funeral Director		5. Social Security Number 6. Se 206-01-0371	x 7. □ M 2□ <b>X</b> F	Age (In yrs. 93	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day 11/15/	/. Year)	9. Birth Cou	place (State or Foreign intry) NY			
Maryland f ehow	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Baltimore Catonsville											10d. Inside City Limits 1 ☐ Yes 2 ☐ No				
	or 28a	Direc	10e. Street and Number			5533	10f. Zi	p Code	20					•			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or iteme 23a or 28a-f show eny injury or other treumatic event, the Madical Examinar must be nutilized at once.	by Funeral Director	719 Maiden Choic  11. Marital Status  1 Never Married 2 Married	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give	ent Ever in U es? [XNo	I.S. 13.	Was Dece If Yes, spe			gin? (Spo , Puerto	ecify Yes or No- Rican, etc.)	14. F	Race - Amer Black, White	ican Indian, , etc.				
	Completed b	3 ∰Widowed 4 □ Divorced  15. Decedent's Ed (Specify only highest gra.)  Elementary/Secondary (0-12)			16a. Dece (Give life.	dent's Usu kind of wo DO NOT L	ork done d	turing most	t of work	ing	16b. Kind of						
	Be	12 17. Father's Name (First, Middle, Last)  Frederick Kimbar	k			Нс	memal	18. Mothe		e (First, Middle, Drew		own, State, Zip Code)					
	To	19a. Informant's Name/Relationship (7  Drew Carlson - s	ype, Print)				13.7	and Numbe	r or Aura	al Route Numbe	e Number, City or Town, State, Zip Code) Ellicott City, MD 21042						
		20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	)	41197	Place of Dispo cemetery, crea rdent (	Crema	tory		06/0	01/2011 Hanover			MD				
Bal	Departiment Departiment Departiment Departiment Departiment Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Depart		21. Signalure of Funeral Service Licen	- wife	u												
760,	SYOU, ate be executed Nysician and Examiner. He burnal-transit	Ilcal Examiner	23a. Part1. Enter the disease, or companies shock, or heart lailure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to attractate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>dere</u> Due to (or b. <u>Due to (or</u>	h line.	vus quence of):								Interval Between			
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 Û No 9 ☐ Unknown	pregnancy			23d. Date of delivery  Month Day Year										
	quires that t in signed by uld be deta	þ	Part II. Other significant conditions on Hyper tension	•		sulting in the u	, •	•				39. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 ➡€nknown					
Vital Records,	: The law requ cate has been page 2 should	Completed	Dementia								24a. Was autop perfo 1 \( \text{Yes} \)	rmed?	prior to death?	completion of cause of			
Vita	nysicien: Th nis certilicate I director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inp	actiont 2	] ER/Outpatie	ni 3 🗆 🗅	Oth			h (Check only o		Other /See	26.1			
Division of	ding PI J. Atter th	atlon: To	27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month,		28b. Time of Injury		28c. Injun Worl			28d. Describe f		6 □ Other (Specify) ry occurred				
Divis	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	treet, lactory, office  281. Location (Street and Number or Rural Route City or Town, State)													
	Ne Hosp 124 hou Ne Fune Hetely fil	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exam one)	ysician: To the b niner: On the bas and manne	is of examina	owledge, dear ation and/or in	th occurre nvestigatio	d at the tin n, in my o	ne, date ar pinion, dea	d place, ith occur	and due to the red at the time,	cause(s) and date and pla	l manner as ce, and due	stated. to the cause(s)			
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0	7 (			9c. Licens				,		Year  In Death  Imore  9. Birthplace (State or Foreign  NY  10d. Inside City Limits  1  Yes 2  No  That Country?  ed States  - American Indian,  (White, etc.  White  siness/Industry  Home  a)  State, Zip Code)  Lty, MD 21042  City or Town, State  er, MD  Family F.H.Indity, MD 21043  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Were aulopsy findings available richt?  3  Probably 4  No  Vere aulopsy findings available richt?  Yes 2 No  No  In (Specify)  ed  ar (Specify)  ed  It (Month, Day, Year)			
			30. Name and address of person who	completed cause	ol death (Ife	<b>м р</b> m 23a) (Туре	Print)	443	377			5/3	1/11				
12	6		Deneen Bowlin M	10 71	maio	den C	hoi	ce	Lane	, 0	atonsv	11/2	Nes	21228			
	Sta Registi		31. Dale filed (Month Day Year)	011	HULL	B. A	arke	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Batter Day Innie Medical leronica 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Charlotke MARY Hal Rel harlotte *5*†. If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 🗆 M 2 🛣 F Months Days (Month, Day, Vear Nountry) Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c City Town or Location 10d. Inside City Limits Director 1 Yes 2 No Charlotte 5+ Marsham 10e. Street and Number 10g. Citizen of What Country? Funeral 29849 20622 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: 3 Nidowed 4 Divorced Black 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other traumatic countries. Elementary/Seconday (0-12) College (1-4 or 5+) Domestic 12 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curtis anicsville 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Garden 4 Donation 5 Other (Specify) 6-6-11 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home A123 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Immediate Cause (Final ATHEROSCIGNOTIC CONDIGVASCULAR DIFFIE Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CORONANT mount YEARS. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin DAYS CEPS1S attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ORTINO (TION Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy performed? death? After this certificate 1 ☐ Yes 2 ☐ No Division of Vital funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifig D (6096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) gum AssociATES MD GILL KAJBINDER

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Onke

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jun 1 Physician/ 2011 10:00 PM Janet Herring Cassell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 34 Browning Street Cumberland Allegany 5. Social Security Number Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 1 M 2 D ^{(M}Aug 23, 1926 Director 216-22-5330 84 Usual Residence of Decedent 28a-f shov 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Director notified MD Cumberland Allegany 1 XYes 2 No 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a within 72 hours after death with 34 Browning Street 21502 USA items 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural" Completed 3 Widowed 4 Divorced Specify. white the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working permit. Page 1 and 2 should be filed within 7, Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Mexicol Elementary/Seconday (0-12) College (1-4 or 5+ homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lavina Rae (Koontz) Herring Edgar Herring 19a. Informant's Name/Relationship (Type, Print)
David Cassell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Browning Street Cumberland MD 21502 son 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial \2 □ Cremation 🐴 □ Removal from State Sunset Memorial Park 6/4/2011 MD Cumberland 4 ☑ Donation 5 ☐ Other (Specify) ignature of 22. Name and Address of Full Fault Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ at how & le ist disease or condition resulting in death) ) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death signed by the a d be detached fo 2 🗆 No g 🗌 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part **i.** 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 □ Probably 4 □ Unknown cate has been signate based by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No 1 TYes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home After this o 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1- Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident 24 hours after death Funeral Director: A Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State

Registrar

DHMH 17 Rev 7/2009

M.D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIKRAMADITYA POONAI

31. Date filed (Month, Day, Year)

JUN 1 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 20^{Yea} 21 р М Wallace de Nobel May 1:25 Richard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Sykesville Fairhaven If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ፟M 2 □ F Months Days Hours Min. Sept. 6, 1930 Ohio 289-26-2954 80 **Director** Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No Sykesville Carroll MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 7200 Third Avenue, U410 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Bace - American Indian. "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 X Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Electrical Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Wallace မ Richard de Nobel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 129 Rabbits Rest, Shepherdstown, WV 25443 James R. de Nobel/Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State May 26, Alexandria,VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 Fact 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pancreatic Physician/ cancer disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter orderlying Cause (Disease or linjury Due to (or as a consequence of): Tanta I To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death should be detached 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed No this certificate has page 2 1 ☐ Yes 2 ☐ No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2. No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred s after death. injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: / Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 12 D34845 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road 1 645 Liber Iliam lan MD

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 May 20 Physician/ 2300 м Lucile Mae Dale Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery General Hospital Olney 9. Birthplace (State or Foreign If Under 1 Year If Under 8. Date of Birth 5. Social Security Number **Funeral** 1 □ M 2 🗓 F Months Days Hours Mau Country) Ohio 293-26-8988 83 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10b County 10c. City, Town or Location Director Silver Spring 1 ☐ Yes 2 🗓 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20906 U.S.A. 15042 Haslemere Court 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Caucasian 3 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Education Child Development Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Edgar H. Liechty Iva Brubaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15042 Haslemere Court, Silver Spring, Maryland20906 Bobby Wayne Dale - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 05/26/2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee Da 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ INTRACRANIA HEMMORRHAGE disease or condition resulting in death) Medical Examiner YPERTENSION Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ jo Month Day Year Pregnant at time of death 9 Unknown the 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital 1 🔲 Yes 2 No ER/Outpatient 3 DOA 1 Inpatient 2 -4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0068026 05/231 MS BANDI PADMAJA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILIP DRIVE OLNEY 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Month May Physician/ 25 9:35 aM Grace D. Dickenson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rockville Montgomery Montgomery Hospice-Casey House Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. July 2, 1930 1 M 2 F D.C. **Director** 577-38-4096 80 Usual Residence of Decedent or 28a-f shoven 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD Silver Spring Montgomery 1 Tes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or Funeral 20903 1507 Dilston Road TISA permit. Page 1 and 2 should be filed within 72 hours after death villed bepartment of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) U.S. Department of Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Umberto DiFrancesco Rose Tortorice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald A. Dickenson/Husband 1507 Dilston Road, Silver Spring, MD 20903 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date GAte of Heaven Cemetery 1 Burial 2 Cremation 3 Removal May 4 ☐ Donation 5 ☑ Other (Specify entombment <u>Silver Spring, MD</u> 22. Name and Address of Facility Francis J. Collins F 500 University Blvd. 21. Signature of Funeral Ser Funeral Home d. W., Silver Home Inc. Liver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition a. Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying burid-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burid strar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No 5 Other (specify) Month Day Year Pregnant at time of death be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy funeral director, page 2 this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospice Other (Specify) Hospital: Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 XNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 🔲 Yes Certificate: 28d. Describe how injury occurred After iniury 1 X Natural 5 Pending 2 🗌 No Accident Investigation within 24 hours after death To the Funeral Director: the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, npleted filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar falle

1355 Piccard Drive, #100, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Debrah Miller , CRNP

MAY 27 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		=	For State Registrar		State of M	aryland		artment of I tificate of L	Health and N Death	1ental Hy	giene Reg. No.		18841		
		П	Decedent's Name (F.	First, Middle, Las	t)					2. Date of De	eath		3. Time of Death		
	Physicia Medic		Margaret	Daniels	Deane					Month May	24,	2011 ^{Year}	9:35 p M		
	Examin		4a. Facility Name (if not	t institution, give	street and number)				r Location of Death		4c. County of Death				
-			Hillhaven 5. Social Security Number			Inc. ge (In yrs. last	hirthday)	Adel	8. Date of Bir	_	. G .	hplace (State or Foreign			
	Funeral Director		579-22-890	4	☐ M 2 12 F	86	Yrs.	Months Days	Hours Min.	Oct. I	5, Year	924 Cot	nplace (State or Foreign Intry) D.C.		
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	eath v tems er mu	Funeral	15021 Wes 11. Marital Status	STNOIM (	12. Was Decedent		13. V	Vas Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-		14. Race - Ame			
21215-0036	filed within 72 hours after death with the Maryland theylgiene.  4d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by I	1 Never Married 3 Widowed 4		Armed Forces?  1  Yes 2  If Yes, Give Year or Dates.			Yes 2 No		nicali, etc.)		Black, White, etc. Specify:White			
5-0	2 hou "natu dical	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Busin (Give kind of work done during most of working)									ind of Business	Industry			
121	within 7; giene. er than t, the Me	Som	Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Ho									wn Home	me		
d 2	filed within al Hygiene. d other tha	Be	17. Father's Name (Firs	st, Middle, Last)					18. Mother's Nam						
/lan	d be f Menta arked aric ev	Bernard Dare Daniels Mary CAtherine Carmody									mody				
	ge 1 and 2 should be file ht of Health and Mental k If item 27 is marked o or other traumatic eve		19a. Informant's Name/Relationship (Type, Print) Patricia Petruzzelli/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 2 London Bridge Court, Silver Spring,												
Baltimore,	Page 1 and nent of Heal ant: If item 3 ury or other		20a. Method of Disposition  1												
Balti	permit. Page Department o Important: If any injury or once.		21. Signature of Funer	ral Service Lic	9//	/	50 50	Name and Address ancis J. Univers	ess of Facility Collins Sity Blvd	Funeral	Hom	e Inc. r Spring	g, MD 20901		
			23a. Part 1. Enter the	disease, or compailure. List only o	plications that cause	d the death.							Approximate Interval Between		
F	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Failure to Thrive											Onset and Death			
Medical resulting in death)  Pue to (or as a consequence of):  Dementia															
		er	Sequentially list conditions, if any, leading to immediate cause. Enter I Inderlyin.  Due to (or as a consequence of):												
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	icate be executed g physician and is the burial-transit	Ĕ	that initiated events resulting in death) Las	st	Due to (or as	a consequer	nce of):								
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876	tificat ing ph e as th	Mec	IF FEMALE:		00 15										
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and to the Funeral Director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1									23d. Date of de Month	livery Day Year		
P.O.	that the ned by detac	y Ph	Part II. Other significa					underlying cause g	iven in Part I.	<b>\</b>			the cause of death?		
ds,	quires en sig ould bo	ted	Hypertens	sion, At	rial Fibr	11Tati	.on.			1 🗆	]Yes ⊉	¹□ No 3 □ P	robably 4 🗆 Unknown		
Division of Vital Records,	The law recte has be had a sho	Completed by								per	s an opsy formed? s 2  N	prior to death?	topsy findings available completion of cause of		
Ta La	ctor, p	Be	25. Was case referred examiner?	to medical	Hospital:				Place of Death (Chec	k only one)					
f Vi	Physic this c al dire	2	1 Yes 2 🔯 I	No	1 Inpa		R/Outpatie 8b. Time o	nt 3 🗆 DOA		ome 5 Res		6 Other (Spec	cify)		
n o	ding I th. After funer	cate		5 Pending	(Month, D	ay, Year)	injury	wor	rk? Yes 2 No	280. Describe	r How Injur	ry occurred			
ivisio	or Atten after deal Director: In by the	Certificate:		6 Could not be determined	e 28e. Place of Ir	njury - At hom tc. (Specify)	e, farm, str	reet, factory, office			(Street ar. own, State		ral Route Number,		
	Hospita 24 hours Funeral leted filled	Medical	29a. Certifier 1 2 (Check 2 only one) 3	Medical Exam	sician: To the best of iner: On the basis of se Practioner: To th	examination a	and/or inves	stigation, in my opin	ion, death occurred a	at the time, date	and place	e, and due to the	cause(s) and manner stated.		
	No the Within	2	29b. Signature and titl		Q ,	ic	)	29c. Licens		397		ate signed (Mont			
			30. Name and address	s of person who a Udochi	completed cause of 90	death (Item 2 55 Che	3a) (Type, vrole	Print) et Drive,	#100, E1	licott	City	y, MD 21	.042		
	Sta Registr		31. Date filed (Month,	Day, Year) Y 2 7 201	2. Regist	trar's Signatui	· pa	del.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Location of Death Examiner MRP. TUS 8. Date of Birth Social Security Number If Under 24 Hrs. Age (In yrs. last birthday) Funeral Nov. 23, 1926 Hours Min. Marviand 1 □ M 2 🏻 F 217-32-6029 84 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c, City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 1 Yes 2 No notified Maryland Washington County Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 23a Funeral U.S.A. 21742 19313 Smallwood Terrace ıral", or items 2 I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 X Married Completed by White Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🛣 No "natural" 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ed other than " event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) Doctor's Office Registered Nurse is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mae Leckron Detrich Stewart B. Detrich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other traconce. 19313 Smallwood Terrace Hagerstown, MD 21742 Donald Dayhoff-husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 6-4-2011 Hagerstown, Maryland Rest Haven Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 13 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has!

To the Funeral Director: After this page 2? autopsy performed? Yes 2 No 1 Yes COLON 25. Was case referred to examiner? Place of Death (Check only one) Other: 2 No 1 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 🗆 28c. Injury at work? onger of Death Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) iniury Natural 5 Pending 1 Tyes Investigation Accident Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date sig /3 05 TW - 10

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 0000 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 12209 Fletchertown Rd. Rowie 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year b. 14, 1 1 M 2 South Carolina 055-22-4423 90 Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1X Yes 2 No Prince George's Bowie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20720 12209 Fletchertown Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian the Medical Examiner Armed Forces? Black, White, etc. ō 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black "natural", Completed 3 Widowed 4 A Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Communications Payroll Manager permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lillie Young Richard Suber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12209 Fletchertown Rd., Bowie, MD 20720 Marsha D. Adams / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/28/2011 Farmingdale, NY 4 ☐ Donation 5 ☐ Other (Specify) Pinelawn Mem. Park 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tore. List only one cause on each line. Cart 1. Enter the shock, or heart and Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ N disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 5 Other (specify) Month Day Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 performed certificate 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5/ Residence 6 Other (Specify) 1 Tyes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of completed filled in by the funeral 28c. Injury at work? 1 🔲 Yes 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 23/ leted cause of death (Item 23a

State Registrar

31. Date filed (Month, Day, Year)

Name and address of person w

MAY 25 2011

HIFDOI-32 Registrar's Signature

(Type, Print)

EFENSE HWY, ANDAPOUSM-D. 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 1800 John L. Diamond may aa 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Dorchester Cambridge Dorchester General Hospita If Under 1 Year | If Under 24 Hrs 3. Date of Birth (Month, Day, Ye 9/7/1938 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number (In yrs. last birthday) **Funeral** Days Hours 1 → M 2 □ F 72 216-34-6458 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b, County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, If a Medical Examinar must be notified at Hurlock 1 ☐ Yes 2 ☐ No Director Maryland Dorchester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21643 127 Miles Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 57-63 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Construction Brick Layer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Virginia Turner John C. Diamond 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 127 Miles Circle, Hurlock, MD 21643 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sl Department of Health an Important: If item 27 is r any injury or other traur Donald C. Diamond - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Hillcrest Memorial Gardens 5/31/2011 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ta ar /Medical Due to (or as a consequence of) Examiner involvir Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 4 Pregnant at time of death P.O. I 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diabeta 24a. Was an autopsy 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

31

State Registr<u>ar</u> Ahmed

Byrn St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

MD

Libib

65528

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month May Physician/ 2011 12:50 AM orenzo Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Talbot Easton The Pines Genesis HealthCare 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign **Funeral** Months Hours Maryland Director 10d. Inside City Limits or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Funeral Director death with the Maryland 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code items 23a 5 A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No ō δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify "natural" Completed 3 Widowed 4 Divorced Black event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) rood-Processing Lorenzo Davis Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Tilahman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R ral Route Number, City or Town, State, Zip Code) Street Wash! 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 1 Burial 2 Cremation 3 Removal from State 28 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of acility
Henry Funeral P.A. Home MD. 21613 23a Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Seat Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? Natural Natural 5 Pending 2 🗌 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c, License number npleted cause of death (Item 23a) (Type, Print)

State Registrar 610

Registrar's Signat

21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 Physician/ Month Year 2011 Davis 3:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital <u>Columbia</u> Howard If Unde Social Security Number 8. Date of Birth
(Month, Day, Year)
Dec 18, 1939 **Funeral** Age (In yrs. last birthday) Year If Under 24 Hrs 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Days Hours Country) 242-62-0278 71 Director Dec Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? Funeral 2300 Westchester Avenue 21228 United States Je filed wittin.

Jental Hygiene.

"arked other than "natural", or ne...

"ent, the Medical Examiner m: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Yes 2 No 1 Never Married 2X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Advertising Director Advertising Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ည Cecil A. Davis, Sr. Mary Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health tem 27 2300 Westchester Avenue Catonsville, Maryland 21228 et of Disposition (Name of Date 20c. Location - City or Town, State Elaine O. Davis/ wife permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 9 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2X Cremation 3 Removal from State Ardent Crematory 4 Donation 5 Other (Specify) 6/1/2011 Hanover, Maryland 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 21. Signature of Funeral Service Licenses 4112 Old Columbia Pike Ellicott City, MD 21043 M00957 ianta maga 23a. Patt \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neum disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner an Sequentially list conditions, if any leading to immediate Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown Unknown Records, P.O. s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed this certificate 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: ျှ 2 Mo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending s after death.

I Director: After din by the fur 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation

Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 20 D648 31 2011 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 1000 5755 Redar Lane Columbia, MD 21044 MD 31. Date filed (Month, Day, Year Registrar's Signature State **JUN 0 1** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jine 2011 1445 Рм Roscoe Dalton Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Examiner Union Hospital Ceci1 E1kton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗓 M 2 🗆 F March II. 1927 Months Days Hours Min. Virginia 223-30-4716 84 **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. # 10d. Inside City Limits Director r 28a-f sh notified a 1 X Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 21921 United States 104 South Tartan Drive 12. Was Decedent Everin U.S. Armed Forces? World 1 12 Yes 2 War II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 🕅 Never Married 2 🗆 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) n 27 is marked other than 's traumatic event ** Automobile Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elias Dalton Mary Vires 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 Page 1 and 2 Barbara S. Taylor/Sister 104 S. Tartan Drive, Elkton, MD 21921 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō Important: If it any injury or o 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Elkton Cemetery 2011 Elkton, MD 22. Name and Address of Facility Hicks Home for Funerals, P.A. ture of Funeral Service Licenses 21. Sign 103 W. Stockton Street, Elkton, MD 21921 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ disease or condition resulting in death) POXIC Lour Medical Due to (or as a consequence of): Examiner 40015 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) 16 your The law requires that the death certificate be executed COLOURA and that initiated events Due to (or as a consequence of) resulting in death) Last the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IE EEMALE: use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? for Month Pregnant at time of death 2 No the g 🗌 Unknown g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate Yes 2 1 Yes 2 No or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 7NO မ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Deat 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number Ad afanos 811 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pino

Registrar

MD

32. Regig rar's Signature

JUN 1 4 2011

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 201T 6:30 Рм Ellis Peggy Lou Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6085 Huntingtown Road Huntingtown Calvert Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Hours Min. 03-02-1930West Virginia Director 232-40-8234 81 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Calvert Huntingtown 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 6085 Huntingtown Road 20639 items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Robert Pear1 Bennett Avis Hester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia K. DiLodovico, daughter 6085 Huntingtown Road, Huntingtown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State MD Veterans Cemetery 106/06/2011 4 ☐ Donation 5 ☐ Other (Specify) |Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ACUTE MYOCARDIAL INFARCTION Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the t IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for t Month Year Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be DEMENTIA Completed 1 Yes 2 No 3 Probably 4 Unknown peen CARDING ARRYTHMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home SX Residence 6 Other (Specify) 1 Yes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 -Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number 28281 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MELSON BENJERS. 9131 PISCATAWAY FO, CLINTON

State Registrar 31. Date filed (Month, Day, Year)

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (Firşt, Middle, Last) Day Year Month **Physician** May 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genera e (In yrs. last birthday) If Under 1 Year | If Under 14 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age In yrs **Funeral** Months Days Hours Min. 102 M 2□ F Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ Whit 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a nbricker 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Nan cemetery, crematory or of Date Department of Important: If It any injury or o 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Cambridge MI Approximate Interval Between Onset and Death Parf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** WOCKS disease or condition resulting in death) /Medical Due to (or as a consi quence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy performed 1 □Yes 2 **P**No 1 🗌 Yes 2 No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifica To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of confifer 29c. License number 56804 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Mg

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death May 23. Physician/ 8:00 am Theodore Myles Farber 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montaomeru Suburban Hospital Bethesda 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Days Hours July 20. Country) New York 130-26-2926 75 **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c City Town or Location Director Boynton Beach 1 X Yes 2 □ No Florida Palm Beach 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 33472 8423 Juddith Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Scientific Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Consultancu Toxicologist permit. Page 1 and 2 should be filed witi Department of Health and Mental Hygien Important: If item 27 is marked other 1 any injury or other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Selma Goldberg Louis Philip Farber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10014 Gardiner Avenue, Silver Spring, MD 20902 Lisa Farber - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Olney. Maryland Judean Memorial Grdns: 05/26/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Signature of Funeral Service Licenses 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death
2 Months Immediate Cause (Final Physician/ Glioblastoma disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) ☐ Ectopic pregnancy in the past 12 months? Month Year Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Diabetes 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation 24a Was an performed? Yes 2 X N 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, p 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X.No 1 X Inpatient 2 ER/Outpatient 3 DDA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 🛮 Certifying Physician; To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20 May 23, 2011 D50534 vernas 11 1 astersa M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Masterson, M.D., 6858 Old Dominion Drive, Suite 104, McLean, Virginia 22101 31. Date filed (Month, Day, Year) State MAY 26 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month May Joseph Gallagher 23 3:30 D Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care-Potomac Montgomery Potomac 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days 1 ☒ M 2 ☐ F Months Hours Feb. 13, Year 1911 Country) 579-28-6713 PA **Director** 100 Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2939 Van Ness Street, NW, #1044 20008 USA death death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: If Yes. Give 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Je filed with...

Tal Hygiene.

Ser than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Should be filed with n and Mental Hygien 7 is marked other th Accountant Federal Government other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke Important: If item 27 is marke Turgunjury or other traumatic of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contraction of the contr Mary Ann Brennan Patrick Gallagher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2939 Van Ness St., NW, #1044, Washington, DC 20008 Florence M. Gallagher/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State June 2 2011 Gate Of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD 22. Name and Address of Facility. Francis J. Collins 500 University Blvd 21. Signature of Ferri Funeral Home Inc. lver Spring MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Blood Loss disease or condition Anemia Medical resulting in death) Due to (or as a consequence of): Examiner Gastrointestinal Bleedin Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury Coronary Artery Disease that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 ☐ No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🛣 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending injury Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and ti e of certifie 29c. License number 29d. Date signed (Month, Day, Year) 9 D35579 2011 more 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Susan J. Miller, MD

MAY 27 2011

31. Date filed (Month, Day, Year)

3. Registrar's Signa

8218 Wisconsin Avenue, #305, Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2.35AM ANTZ Male Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, County of Death Howard Courty Gener Howard olumbia 9. Birthplace (State or Country)
Washington, If Under 1 Year If Under 24 Hrs. Social Security Number Sex. 1 X M 2 □ F **Funeral** Days Apyonth, Pay, Yea 1920 Months Hours 91 Director 577-18-8770 Usual Residence of Decedent show 10a. State 10c. City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2X No Silver Spring Maryland Montgomery 10e. Street and Number 10a. Citizen of What Country? Funeral United States 20906 15300 Pine Orchard Drive #3F 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. white Specify: "natural", Completed 3X Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7g Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Accounting Accountant event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lena Sherling Benjamin Gantz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Gantz, Son 13918 Flint Rock Road, Rockville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) any injury or Lebanon Cemetery 05/27/11 Adelphi, MD 21. Signature of Hungra Service Licensee Porchinsky Hetirew Funeral Home U01008 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2e No Other: မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work' 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12 May 24, 2011

State

31. Date filed (Month, Day, Year)

MAY 26 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ramesh Sabapathi 201-109 Back ANU Mack Road Baltimere Maylas 2121

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 18853 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAU Physician/ 1:15 AM Leroy Franklin 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown 8. Date of Birth
(Month, Day, Year)
Jan. 16, 1931 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 1**XX**M 2 □ F Months Maryland Hours **Director** 220-26-5319 Usual Residence of Decedent 28a-f show 10c. City, Town or Location aţ 10a. State 10b. County 10d. Inside City Limits Director Examiner must be notified 1 Yes 2XXNo Maryland Washington Sharpsburg 0 10f. Zip Code 10g. Citizen of What Country? Funeral 3425 Harpers Ferry Rd. 21782 USA , or items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc. ģ 1 Never Married Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", 3 
Widowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 8 Dump Truck Driver Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ellsworth Morrell Gray Martha Louise Ebersole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 <u> Helen Gray - Wife</u> 3425 Harpers Ferry Rd. Sharpsburg, Maryland 21782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State al from State 1 X Burial 2 Cremation 3 Res 4 ☐ Donation 5 ☐ Other Specific Mountain View Cemetery 2011 Sharpsburg, Maryland Osborned Funeral Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Fall 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (o consequence of) eur The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria non Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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Director: After this certifice 25. Was case referred to medical of Vital the funeral director, BB B 26. Place of Death (Check only one) 2 XNo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 잍 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred injury 5 Pendina Division work?
1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signatur D60228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JN-4 xttue Ave N State gistrar's Signatu

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Year 2011 1827 PM Anita Louise Haines Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 24, 9. Birthplace (State or Foreign Country) Maryland 6 Sex 7. Age (In vrs. last birthday) Funeral Days Hours 1 □ M 2 🛭 F 214-42-2296 66 Director Usual Residence of Decedent and Mertial Hygiene.

I is marked other than "natural", or items 23a or 28a-f show

is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13708 Kenneth Street 21742 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. Completed by 1 ☐ Never Married 2 🕅 Married 1 Yes If Yes, Give 2 X No 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Albert Castle Catherine Virginia Sharer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dearl W. Haines, Sr. - Husband 13708 Kenneth St. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Bem Donation 5 Other (Spery) Cedar Lawn Mem. Park : 06-03-2011 Hagerstown, Maryland 22. Name and Address of Facility Osborne Funeral Home, P.A. . Signature of Funeral Service 425 S.Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Fibrosis Physician/ Advance Stage disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Obstructive that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 No Month Year Dav Pregnant at time of death 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 X No Other: Certificate: To 1 Inpatient 2 XER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 00069606 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD KODUAH # 306, Hagerstown St. 324 E. State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amended # 6perFH FCHD KS 5/26/11 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:15A M1 Margaret L. Harrison 2011 MAY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Boonsboro Reeders Nursing Home If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** March 30,1912 218-38-0807 Months Hours Maryland **Director** 99 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Knoxville Maryland Washington 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21758 United States 921 Israel Creek Court items 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian permit. Page 1 and 2 strough --Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or if any injury or other traumatic event, the Medical Examin Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Yes, Give 2X No 1 ☐ Yes 2 XNo Specify Completed 3 X Widowed 4 □ Divorced Specify. White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) School Systems Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katie Lorena Henry James Holder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2825 Chestnut Grove Rd., Keedysville, MD 21756 Kathryn Hardy / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Brownsville, Maryland Brownsville Cemetery 5/28/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1100 North Maple Ave., Brunswick, MD 21716 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part 1. Enter the disea Approximate Interval Between Onset and Death shock, or heart failure. List only one cause of Immediate Cause (Final MILUNE Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SIMLE DEMENTA KND monter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exam forms executed CIMANIC inding physician and use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 Yes 2 You Month Pregnant at time of death 5 Other (specify) the detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 No Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☑ No Yes 2 No or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours a er death Funeral Director: / fter this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MAY 4656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301-432-8470 GHAZALA OADIR, 20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713

Registrar

State

egistrar's Signatur

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ATHAN HOWARD 775 6:09 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE OF MARYLAND WED If Under 24 Hrs. If Under 1 Year Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD Country) 1 X M 2 □ Months Hours 1/03/1953 **Director** 216-58-8579 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? event, the Medical Examiner must be Funeral items 23a 20850 USA 329 Lincoln Avenue should be filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō ģ 1 XNever Married 2 Married 1 ☐ Yes 2 No Specify: If Yes. Give Specify: "natural" Completed 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) B & B Refuse Sanitation Worker marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nathan Howard, Sr. Lorraine Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant; If item 27 is 20732 Crystal Hill Circle, #A, Germantown, MD 20874 Shawntori Howard/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit, Page 1 Des artment of Important; If it any injury or o cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/26/11 Ardent Cremation Sv Hanover, MD 2) Signature of Funeral Service Licen 22. Name and Address of Facility Snowden Funeral Home DUX# 246 N. Washington St, Rockville, MD 20850 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line Immediate Cause (Final Onset and Death Hodeti Physician/ disease or condition resulting in death) NON Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): use as the burialphysician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Other (specify) Month Day Year Pregnant at time of death 2 🗌 No the detached 9 Unknown 9 Unknown sate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 1 Natural Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 🔲 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records,
To the Hospital or Attending Physician: The law requires within 24 hours after death.
To the Funeral Director: After this certificate has been signompleted filled in by the funeral director, page 2 should by

Baltimore, Maryland 21215-0036

Box 68760

P.O. I

State 31. Date filed (Month, Day, Year)
Registrar NAY 2 6 2011

SHANDER, M.D. 22 S GREENE ST 192. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29a. Certifier

(Check 2 Medica only one) 3 Certify

29b. Signature and title of certify

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

NPI # 1013233378

29d. Date signed (Month. Day, Year)

BALTHMOREMD 220

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jun<u>e</u> 2011 Willie Lou Henley 1256 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 23 Otter Point Road E1kton Ceci1 Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Days Hours AUGnth Day, 1926 Virginia Director 226-28-4150 84 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23 Otter Point Road 21921 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give 3 X Widowed 4 ☐ Divorced Specify: Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker In Her Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Burnette Lillian Lucado 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Henley, Sr./Son Jensen Lane, Elkton, MD 21921 20b. Place of Disposition (Name of Gilpin Manor Manor Memorial Park 20a. Method of Disposition June Bate 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Elkton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals. 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ementia Unknum disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of confine 29d. Date signed (Month, Day, Year) 6.7.2011. 00023322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SSACHDEV MD 126A, E FLICKS

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUN 1 4 2011

P.O.

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Elk (m MD 21921

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State of Manyland / Department of Health and Mental Hygiene

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	To the To the compl	2	29b. Signature and title of o				29c. Licen		20/2	29d. Date sig	gned (Month, I	Day, Year)				
	10 sh		30 Name and address of r	person who completed cause of	death	23a) (Type,	Print)	1	1/	1	101	2017				
	, V.		31, Date filed (Month; Day,	MS 13424	trar's Signatu	NSC,	Varia	Here	Hage	rfau	1, ML	1 217	42			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4 Day 201 Tar Julieth Edith 12:23 Pm Hunter Opal Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northampton Manor Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 F Hours **Director** 98 579-28-7783 March 6, permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Frederick Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Burgess Hill Way Apt. 219 Funeral 21702 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 🗔 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Elizabeth Williams Edilir Burton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 Doris Dr. Owings, Md. 20736 Ronald E. Hunter (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) June Smithsburg Crematory Smithsburg, Md. Signature of Funeral Service License 22. Name and Address of Facility 12525 Bradbury Ave. M01414 J.L. Davis Funeral Home Smithsburg Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the Unknown 9 Unknow is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has page 2 autopsy perform death? 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) after death.

Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 Yes 2 No 5 Pending Investigation 6 Could not be completed filled in by the Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie SM ef person who completed cause of death (Item 23a) (Type, Print) 15 ohr 32. Registrar's Sig Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep State of Maryland / Dep State of Maryland / Dep Registre/MEND#23bpenMD,6/2/11;BMJ,McOb	partment of Health and Mertificate of Death		ienen	18862
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	Physici /Medi		Barbara Jean Ingram		05/24	/2011	1am M
1	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	
			Heartland Nursing Home  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Adelphi If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince	
	Funeral Director		5. Social Security Number  579-72-2857  Usual Residence of Decedent  6. Sex 1 M X F  7. Age (In yrs. last birthday)  Yrs.	Months Days Hours Min.	08/02/		irthplace (State or Foreign Country) Vashington,
	/land		10a. State 10b. County 10c. City, Town or I	Location			10d. Inside City Limits
	Mar.	tor	DC Washing	gton			1X Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What (	Country?
	23a	rai	5118 Just Street NE	20019		USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland If Health and Mental Hygiene, item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avant, the Medical Exerciter must be inclined at	by Funeral	11. Marital Status  1. Was Decedent Ever in U.S. Amed Forces?  1. Never Married 2 ☐ Married  3. ☐ Widowed 4. ☐ Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1. ☐ Yes 2. ☐ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes  No Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	
21215-0036	tural	edt	15. Decedent's Education 16a, Dec	edent's Usual Occupation		16b. Kind of Busines	ss/Industry
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212	d within giene. er than	mo.	12th Cle	erk		Federal	Government
	al Hygid other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	
<u>Va</u>	ould be Mental arkad o	2	William A. Ingram		GOODWI		
Maryland	2 sho	11 1		iling Address (Street and Number or Rui			
	1 and 2 Health am 27			8 Just Street N		ington D 20c. Location - City o	
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Ba	permit. Departr Importu any inju		0777	²shead afunfail n 5732 Georgia Av	lome & (	Crematio	n n DC 20011
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00		iete	Common Artun Disease	J	24a. Wasa	n 24b. Were	autopsy findings available
	sician: The law certificate has b irector, page 2 st	mo	Secondam Hyperpara Hypoidis	***************************************	autops perform	med? _ death	o completion of cause of ? es 2□ No
Vital		BeC	25. Was case referred to medical	· /	th (Check only on		
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n of	ng Ph ter th neral		27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury Injury		28d. Describe ho	ow injury occurred	
Sio	endir eath. or: Al	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Diractor: After this certifical completely filled in by the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Si City or Town		Rural Route Number,
	he Hospi n 24 hou he Funar pletely fill	Medical	29a. Certifier (Check only one)  1. Certifying Physicien: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occur	and due to the c red at the time, d	ause(s) and manner late and place, and c	as stated. due to the cause(s)
	To the within 2 To the Toomplet	Σ	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Mo	onth, Day, Year)
U	5		MD MD	47867		2/24/1	/
			30 Nintand address of person who completed cause of death (Item 23a) (Typenay Zuniga 4761 Rando / ph	e, Print) Rel & ZIB, ROCK	villa.	MD 208	322
	St Regist	ate	31. Date ided (Month, Day, Year) 32 Registrar's Signature	all de	7		

DHMH 17 Rev 1/2001

Amend #23a, b,c AACO HeaLIH Dep		E 0E 11 TEXT	Type or Pri					_			·.	
Amend #1 per PHY = State Amend Item 25 per me,g916,06/21/2011dhb Registrar  1 December 1 Name (First Middle   201)												
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Examine		Washing for	Adventis	+ H	ognital			ar A	4	ic. County of Dea		
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		Usual Residence of Decedent						May 29	9, 15	9/9  was	nington, D.C.	
rryland a-f sho ied at	Director	10a. State 10b. County DC		10c. Cit	y, Town or Loc		on				10d. Inside City Limits	
the Ma or 28s	ב ב	10e. Street and Number				Vashingt 10f. Zip Code			10a. 0	Citizen of What C	1X Yes 2 No	
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r death	by ru	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 X Yes 2			vas Decedent of Yes, specify Cul	Hispanic Oriç ban, Mexican	gin? (Specify Yes or No n, Puerto Rican, etc.)	o-	14. Race - Ame Black, Whit		
DO36 Irs afte	eg p	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		2002	☐ Yes 2 🛛 N	lo Specify:			Specify: Bla	ack	
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Meath ar and a 2 sh		Deborah Joyner/S			I .			er or Rural Route Numb Nashington ,			p Code)	
Ore, e 1 an t of He If item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [	Removal from State		lace of Dispos	sition (Name of atory or other pla		Date		Location - City or	r Town, State	
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he dea		1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a	t time of d	eath 5 ∟	Other (specify)	· · · · · · · · · · · · · · · · · · ·			MORITI	Day Year	
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Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director, Medical Certificate: To Be		(Check 2 L Medical Exam	sician: To the best of iner: On the basis of e	xamination	and/or investig	gation, in my opin	ion, death occ	curred at the time date	and place	e and due to the	cause(s) and manner stated	
To the within To the comple	١,	only one) 3 L Certifying Nur 29b. Signature and title of certifier	se Practioner: To the	best of my	knowledge, de	29c. Licens		and place, and due to t		(s) and manner as ate signed (Monti		
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w.	1	30. Name and address of person who	completed cause of d	eáth (Item	23a) (Type, Pr	int)	1.10	Tallima	0	K IN	0	
State	3	6/19 (Month, Day, Year) MAY 25 201	32 Registra	r's Signatu	ye 1	JIVII F	10 €	IN II INNO	101/	11 1011	-	
Registrar		MAYZOZU	Come	U A	. par	Kel						

11-04279 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Raymond Jordan 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First_Middle Last) Physician/ Month Day June 7, 2011 1317 hrs Medical Examiner ORDAN MOND 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death Laurel Regional Hospital Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Director Country) -90-558 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No or 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f abov her traumatic event, <u>the Medical Examiner must be notiffed at once.</u> Director 10g. Citizen of What Country? 10e. Street and Number Funeral Race - American Indian, Black, 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces' 1 Never Married 2 Married 1 Yes If Yes, Give Year 80-82 Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after.
Department of Health and Mental Hygiene. 4 Divorced 1 Yes 2 No specify: Specify: WhITE 3 Widowed 2 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KAYMOND ADAM ဥ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number ROSEM. JORDAN 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 2 Cremation 3 Removal from State W. ARUNDE CREMATORY Donation 5 Other Specify: 22. Name and Address of Facility 2601 MOUNTAIN RO. PABADENA, or actions that caused the death. Do not enter the mode of dying, such as cardiac Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Heroin Intoxication Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical AMENDED 23a, 27, 28a-f, per me, g916 6-23-11 sm X UNPENDED attending physician for use as the burial -Eox 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the <u>о</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed Division of Vital Records, certificate has been 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of page 2 performed? death? Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other: Inpatient 2 V ER/Outpatient 3 DOA this 1 Yes After 28a, Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 Yes 2 X No 5 Pending 24 hours after death. fd 6-7-11 fd 11:18 am ŧ 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide or Town, State) 534 Maryland House Of Corrections Rd. Jessup, Md. (Specify) found in jail cell Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 8, 2011 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Patricia Aronica-Pollak MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

DOME

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Peter, Krejci Physician/ 2011 11:33 am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Mudical Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, JL 12, 1 💥 M 2 🗆 F Hours Min. Days **Director** 214-52-2611 64 Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City. Town or Location notified at 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2 X No MD Germantown Montgomery 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must ber Funeral United States 20874 13326 Bayberry Drive death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 🛱 Divorced Specify: Caucasian Completed Year or Dates.1968 - 1971 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene.

It is marked other than traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Automotive Industry Automotive Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Hollash Krejci Otakar .. Page 1 and 2 should b tment of Health and Mer tant; If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher K. Krejci, son 368 Apache Plume Street, Brighton, CO 80601 Department of H Important: If ites any injury or oth once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/22/2011 Glen Burnie, MD Atlantic Crematory ²² Name and Address of Facility Thibadeau Mortuary Service, p.a. 7 Park Avenue, Gaithersburg, MD 20877 M00956 Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition hepatorenal Syndromo Medical resulting in death) Due to (or as Examiner 30 days Sequentially list conditions, day, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi that initiated events ŭ resulting in death) Last Due to (or as a consequence of): attending physician cal Division of Vital Records, P.O. Box 68760 Physician/Medi IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 W No 2 🗆 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manger of Death 28a. Date of Injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ✓ Natural (Month, Day, Year) 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation M within 24 hours after death To the Funeral Director: the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) lun 17 1457679458 0 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene St Baltimore, MD IKUMI Suzuki 31. Date filed (Month, Day, Year) **MAY 2 4 2011** 

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month P.M. Evelyn Elizabeth K1ine Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Reeders Memorial Home Washington Boonsboro Social Security Number if Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 30, 1911 **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Director Maryland 213-40-6983 99 June Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Washington Boonsboro 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 141 South Main Street 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examis once. þ 1 Never Married 2 Married ☐ Yes 2 X No If Yes, Give Year or Dates. 1 Yes 2 No Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emory C. Stotler Ada Mae Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty M. Walter/daughter 10738 Grindstone Run Road, Myersville, Maryland 21773 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Boonsboro Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 05/31/11 Boonsboro, Maryland Signatu of Funeral Service Licensee 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike, Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ REDroviscular disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 13 Chaenu Month Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed MILUR THUVE Œ MONTHS. burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): To the Funeral Director; After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?

1 Yes 2 VNo
9 Unknown 5 Other (specify) Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Dunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? ☐ Yes 2 PN 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ည 1 ☐ Yes 2 🐼 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Tes 2 No Accident Investigation after death 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) apparsf 20311 Registrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0140 M 2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** uni Rehabilitation & Nursing Ctr Wicomica If Under 1 Year Months Days 8. Date of Birth (Month, Day, If Under 24 Hrs.
Hours Min. Birthplace (State or Foreign Country) **Funeral** Months Director Usual Residence of Decede 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Res 2 No 10g. Citizen of What Country? U 12. Was Decedent Ever in U.S. Armed Forces?

1 Pes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) hemical 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 861 9 OPen Meadow hae 0 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mid shore Crematory Contents
by Collect Curran branchiff 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Date 20c. Location - Oty or Town, State May 25,2011 Cambridge, NID 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Ferneral Home, P.A. 22. Name and Address of Facility 510 Washington 23a. Part 1. Enter the disease, or complications that a sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Cambridge, MD 21013 Approximate Interval Between shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner quentially fist conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached. 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 2 E 10 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MiD 31. Date filed (Month, Day, Year) State Registrar

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Ph_sician/ Medical Æxaminer To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

### Wilbur R. Keefer  ### Wilbur R. Keefer  ### A Posity Name of not institution, get street and numbers  ### Kind Hospice House  ### Kind Hospice House  ### Milbur R. Keefer  ### Wilbur R. Specification  ### A County of Death  ### Kind Hospice House  ### Wilbur R. Wilburg Position  ### A Sould Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social Social	123
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Oliver O. Keefer    10a Informent's Name/Relationship (Type, Print)   345. Mailing Address Street and Number or Rural Route Number; City or Town, State, Zip Occ. Ruth V. Keefer / Wife   345 Catocttin Avenue, Frederick, Maryland 21   20a. Method of Disposition   3   Removal from State   20b. Deace of Disposition   1   8   Burial 2   Chemation 3   Demoval from State   4   Donation 5   Other (Specify)   Prospect Cemetery   5/28/2011   Mt. Airy, Mary   21. Signature   formal Service   22   Demoval from State   Prospect Cemetery   5/28/2011   Mt. Airy, Mary   22   Demoval from State   Prospect Cemetery   5/28/2011   Mt. Airy, Mary   22   Demoval from State   Prospect Cemetery   5/28/2011   Mt. Airy, Mary   22   Demoval from State   Prospect Cemetery   5/28/2011   Mt. Airy, Mary   22   Demoval from State   Prospect Cemetery   5/28/2011   Mt. Airy, Mary   22   Demoval from State   Prospect Cemetery   5/28/2011   Mt. Airy, Mary   22   Demoval from State   Prospect Cemetery   5/28/2011   Mt. Airy, Mary   22   Demoval from State   Prospect Cemetery   5/28/2011   Mt. Airy, Mary   22   Demoval from State   Prospect Cemetery   5/28/2011   Mt. Airy, Mary   22   Demoval from State   Prospect Cemetery   23   Demoval from State   Prospect Cemetery   24   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval from State   25   Demoval	rnment_
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examiner?	2 LATNO
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29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Day, Day, Day, Day, Day, Day, Day	
29b. Signature and title of certifier  29c. License number 29d. Date signed (Month, Day) 5/25/28 41	Route Number,
Donels n ms 321936 5/25/2011	se(s) and manne
	ay, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A . JONE LON MD 65C THEY MAS COMMON DE., FREDERICE, MD 217  Item 31. Date filed (Month Dev Year 6 2011 32. Rigistrar's Signature).  January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. January J. Ja	70Z

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State Registrar 300 West Nonth Street, Frederick, Maryland 21701

M.D.,

Registrar's Signat

Robert L. Kaufmann,

MAY 24

31. Date filed (Month, Day, Year)

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		-	_ State	ite or iviaryiano		tificate of l				10010
			Registrar  1. Decedent's Name (First, Middle, Last)		007	tineate or i		2. Date of Death	g. No.	3. Time of Death
	Physicia Medic			Nolon Lyon				May 2:	5, Day 2011 Year	8:10 ам
	Examin	er	4a. Facility Name (if not institution, give street an				r Location of Death		4c. County of Death	
_			Renaissance Gardens  5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year	er Spring I If Under 24 Hrs.	8. Date of Birth	<del></del>	George's
	Funeral Director		578-09-8283 1 🖾 M 2	□ F 7. Age (iii yis. las	Yrs.	Months Days	Hours Min.	May 04,	rear 1921 Wash	ington, DC
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County		Town or Loc		ilver Spr	ina		10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	or 28a	<u> </u>	Maryland Montgome  10e. Street and Number	rcg		10f. Zip Code	avec spic		ng. Citizen of What Co	untry?
	with the 23a cust be	erai	3126 Gracefield R	oad, #312			20904		u.s	-
	tems er mu	ᇤ	11 Marital Status 12. Was	s Decedent Ever in U.S. ned Forces?	13. V	Vas Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
စ္တ	fter d	þ	1 Never Married 2 🗷 Married 1 🔀	Yes 2 ☐ No	1	Yes 2 X No		riloari, oto.,	Black, White Specify:	
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21215-0036	iled within Il Hygiene. other thar	Completed	Elementary/Seconday (0-12) Coll	ege (1-4 or 5+) 5+	Assis	tant Dir	ector of gulation	Super-	Federal Re	serve
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lan	l be fi fenta rked tic ev	욘	Rober	t Lyon, Sr.				Mamie	Belle Medi	nger
Maryland	should be file n and Mental h 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print	1)	19b. Mailir	ng Address (Street	and Number or Rura	al Route Number, (	Dity or Town, State, Zip	Code)
Σ	and 2 s Health tem 27 i		Katherine Lyon - Spor	use	3126	Gracefie	ld Rd.,#3	12, Silve	r Spring, I	MD 20904
ore	of Heritar		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Remova		ace of Dispo	sition (Name of natory or other pla	ce)	Date 2	0c. Location - City or	Town, State
Ĕ	Page ment tant: ury o		4 Donation 5 Other (Specify)	Cole					Arlington,	
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		21. Signature of Funeral Service Licensee  Kathina. Func	di Funeral ilver Spri	Home, Inc. ng, MD 20904					
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause		Do not ente	er the mode of dyir	ng, such as cardiac o	or respiratory arres	t,	Approximate Interval Between
-	Physician/									Onset and Death
Œ	Medical		resulting in death)	Cerebrovas Due to (or as a conseque	ence of):	Accuen	<u> </u>			
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9289	ath certificate be exe attending physician for use as the burial	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If ye	es, outcome of pregnan	су				23d. Date of del	ivery
Вох	atter	icia	in the past 12 months?	Live Birth 2 🔲 Fetal Pregnant at time of de		Ectopic pregnan Other (specify)	cy		Month	Day Year
Э. В	the d	hys	9 Unknown 9 L	Unknown						
P.O.	that gned b		Part II. Other significant conditions contributing	ng to death but not resu	lting in the u	nderlying cause gi	ven in Part I.		acco use contribute to	
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Re	The la	Son						perform 1 \sum Yes 2	led? death? L No 1 ☐ Yes	2 🗆 No
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0 0	ding F h. After funer	Certificate:	1 ☒ Natural 5 ☐ Pending	. Date of injury (Month, Day, Year)	28b. Time of injury	wor		28d. Describe how	v injury occurred	
Sio	Attender deat	ij	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	Place of Injury - At hon	ne, farm, str		7100 2 1110	28f. Location (Str	eet and Number or Rui	al Route Number,
Division of Vital Records,	ital or / urs after ral Dire		4   Homicide determined	building, etc. (Specify)				City or Town,		
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  Within 24 hours after death.  Completed filled briector after this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To Medical Examiner: On 3 Certifying Nurse Pract	the basis of examination	and/or invest	tigation, in my opini	on, death occurred a	t the time, date and	place, and due to the o	ause(s) and manner stated.
_	Vit Vit		29b. Signature and title of certife		1	29c. Licens		29	d. Date signed (Month	
	(1)		1 / 1000/4	ellica	ne		D24093		May 25,	2011
	•		30. Name and address of person who complete Mark Parkhurst, M.D.	. 3110 Grad	refiel	d Road.	Silver Sp	ring, Ma	ryland 209	04
	Sta	te	31. Date filed (Month, Day, Year) MAY 2 7 2011	3 / Registrar's Signat	lro-Lo	40				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month Michael Alfred Lee 26 2011 11:40 Aм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Calvert. Prince Frederick Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Country) Virginia 1 ₹ M 2 □ F Months Days Hours 02/06/1950 229 -66- 0858 Director 61 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the M dical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Calvert Huntingtown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1250 Hollyberry Court 20639 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 1 Married Yes 2 X No Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify White Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 nand Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Executive Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Alfred Lee Audrev Ruth Garris traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau. Teresa Maria Lee / Wife 1250 Hollyberry Court Huntingtown, Maryland 20639 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 06/01/2011 Wesley Cemetery Prince Frederick, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, PA. Kyle S. Simons M01206 4405 Broomes Island Road Port Republic, Maryland 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final nset and Death Priysician/ disease or condition resulting in death) wou Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir the Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 by the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ρ Day 5 Other (specify) Month Year Pregnant at time of death be detached 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ Completed 2 No 3 Probably 4 Unknown page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify, 2 No ျှ 1 Tes Inpatient 2 ER/Outpatient 3 DOA Funeral Director: After this 28a. Date of injury (Month, Day, 27. Manner of D th 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation M filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direc determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: for the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one nd tille of certifi 29b. Signature 26 and address of per red cause of death (Item 23a) (Type, Prin Jen 90 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 7:13 P M 27 May Patricia Ellen Landry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Burnett-Calvert Hospice House Prince Frederick . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2X Months Days Hours Min. 10-15-1946 Texas 64 Director 456-78-9963 Usual Residence of Decedent 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Director Dowell 1 Yes 2 X No MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20629 613 Oyster Bay Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Yes 2 X No Yes, Give 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates ed other than "nature event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha Computer Security Specialist U S Government permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important: If item 27 is marked other it any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Una Hughes ဂ္ Clarence Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 613 Oyster Bay Place, Dowell, Maryland 20629 Henry G. Landry - Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Solomons UMC Cemetery 6-1-2011 Solomons, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence or) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No certificate 1 Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 2 28a. Date of injury (Month, Day, Year) 27. Manner of Deal 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred nin 24 hours after death.

the Funeral Director: After the properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled in by the funeral properted filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled filled fil Certificate: 1 Natural 2 Accident 3 Suicide 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29c. License number eted cause of death (Item 23a) (Type, Print) Jaymon Prince W 238 32. Registra s Signature State MAY31 Registrar

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200		Registrar  1. Decedent's Nam	ne (First, Middle	. Last)				Cer	uncau	e or L	Jean		T ₂ D	ate of De	Reg. N	0.	1	3, Time	Q 7 3
Physiciar Medica	al :	G1adys	Mae	Lloy									Ma	lonth Ly	2				55A M
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the Hospi	Medical	(Check 2	Certifying Medical E Certifying	xaminer:	On the basis	of examinat	ion and/or	investi	igation, in r	ny opinio	n, death	occurred a	at the tin	ne, date a	and plac	e, and due	to the ca	use(s) and m	anner stated
vith Con		29b. Signature and		Sir	drew	n			- 1	. License D006					29d. Da	ate signed M		Day, Year)	11
238		30. Name and addre								ite	101	, Wa	ldoı	f,MI	20	601			
State Registrar		31. Date filed (Monti	h, Day, Year)	1 201	32. R/g	istrar's Sign	nature .	43	arke	/									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First_Middle_Last.) 2. Date of Death Month May Physician/ Day 2011 Year 21 Carl Smith Moore 8:54 а Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Brooke Grove Rehab. and Nursing Center Sandy Spring Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Oct. 8, 1 XM 2 🗆 F Months Days Year 913 97 Director 403-30-0889 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No MD Silver Spring Montgomery 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20906 USA 3408 Parker Creek Lane items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces:/ 1 XYes 2 ☐ No Black, White, etc or, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 er than "natural", c , the Medical Exam Specify: White If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced WWII era 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working i Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NASA 2 should be filed with h and Mental Hygien 7 is marked other th Architectural Engineer age 1 and 2 should be filed wit of Health and Mental Hygie t: If item 27 is marked other or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Laura Smith Thurman Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3408 Parker Creek Lane, Silver Spring, MD 20906 Alma G. Moore/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May Date 23 permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2011 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Prancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 10 yrs Ph, sician/ Atherosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) and - ansit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown g Unknown n signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation, Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? 1 ☐ Yes 2 ☐ No Yes 2**X** N Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 K No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DCA eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c, Injury at 28d. Describe how injury occurred To the Hospital or Attending 5  $\square$  Pending **∐***Natural 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2+1 D31918 May 23, 2011 0. 14 0 30 Name and address of person who Warren Ferris, MD completed cause of death (Item 23a) (Type, Print) completed cause of death (Item 23a) (Type, Print) 3305 North Leisure World Blvd., Silver Spring MD 20906

State

Registrar

31. Date filed (Month, Day, Year)

MAY 24 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 23, Physician/ 2011 I. Michael 7:30 p Morris Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 0670871918 Country) 1 ★ M 2 | F 92 Director 107-16-8132 Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. Count 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 √ Yes 2 □ No Md. North Bethesda Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 5809 Nicholson Lane #303 20852 items 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō þ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify. White "natural" 3 Divorced 4 Divorced Year or Dates. WW-I-I Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Pediatrician Medical permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other tanny or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph L. Michael Esther Novig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5809 Nicholson Lane #303 North Bethesda, Md. 20852 Mildred Michael/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gardens 05/26/11 4 Donation 5 Other (Specify) Olney, Md. Signature of Juneral Service Licenses Haward Sage Tib Funeral Direction 1091 Rockville Pike Rockville, Md. Edward Sagel 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Ph_sician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine sician and burial-transit Severe Aortic Valve Stenosis or Attending Physician: The law requires that the death certificate be executed after death. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) led by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? **Director:** After this certificated in by the funeral director, pag 1 Yes 2 No Yes 2X No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 \( \) Nursing Home 5 \( \) Residence 6 \( \) Other (Specify) Hospital: 1 Tes 2 🔀 No Certificate: To 1 Nation 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 X Natural work?
1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title certifie 29c. License number 29d. Date signed (Month, Day, Year) D63285 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Ave. #515 Checy Chase, Md! Dr. Eva Hausnerova 31. Date filed (Month, Day, Year State

Registrar

DHMH 17 Rev 7/2009

			Ple	ease Type or					•	_	jible.	
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æ	Examin		4a. Facility Name (if not institution		ber)		4b. City, Town, o	r Location of Death		4c. County		
-	, 		5231 Mar1boro 5. Social Security Number		7. Age (In yrs.	last hirthday)	Capitol	Heights If Under 24 Hrs.	8. Date of Birt			orges place (State or Foreign
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40	r dear	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Ma</li></ul>	12. Was Deced Armed For arried 1 ☐ Yes	ces?	S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ ck, White,	
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	q pa	3 ☐ Widowed 4 🗓 Divorce	If You Give			1 ☐ Yes 2 🗶 No	Specify:		Specify	Wh	ite
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Maryland	should be file n and Mental H is marked o raumatic eve		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ng Address (Street	and Number or Ru	rai Route Numbe	r, City or Town, S	State, Zip (	Code)
	nd 2 sealth m 27		Frances Smith /	Daughter			Clearvie	w Drive,	Owings,	MD 207	36	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Buria! 2 ☐ Cremation		State	cemetery, cren	sition (Name of matory or other place		Date	20c. Location		
Ħ	permit. Page Department o Important: If any injury or once.		4 Donation 5 Other  21. Signature of Funeral Service		Che		Highlands		27/2011	Port R		ert, P.A.
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Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 D Fet ant at time of	al death 3	Ectopic pregnand Other (specify)	су			te of delive	ery Day Year
P.O.	s that th gned by be detac	by Ph	Part II. Other significant condit	tions contributing to de	ath but not res	sulting in the u	inderlying cause given	ven in Part I.				ne cause of death?
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Division	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical Certificate:	3 Suicide 6 Could	d not be 28e. Place of	of Injury - At ho g, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	er or Rural	Route Number,
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	To the within To the Compl	Σ	only one) 3 \(\subseteq\) Certifyin 29b. Signature and title of certific		A	y knowledge, t	29c. License			29d. Date signer		
			Lagra	da /2/	Jes	000	M	60555	27	MAY	25	72011
	3 KW		30. Name and address of person	who completed cause	of death (Item	23a) (Type, P	Print) Tal Dr	ine, C	Lever 4	M	7 mg	20781
	Stat Registra		31. Date filed (Month, Day, Year)	Serena 32. Re	gistrar's Signa	ture		,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 45A M 22 mara /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Raven 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 □ F 67 Maryland 218-36-5566 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shorthe Medical Examinar must be notified at Annapolis 1 XYes 2 No Maryland Anne Arundel Director 10e. Street and Number 10g. Citizen of What Country? 21403 USA 1015 Apt S8 Norman Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No If Yes, Give Year or Dates: 66-69 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Truck Driver 9 h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Olive Collison Bernard Murray ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau 15 A Elliott Road, Annapolis, MD 21403 Olive Vlna - Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State MD Vet Cem Crownsville 5/26/2011 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee Myden 147 Duke of Gloucester St, Annapolis, MD 21401 Weber Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final un Knousm **Physician** mphoice cale disease or condition resulting in death) /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are little indepth), or the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of the capture of th Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year Day 5 Other (specify) signed by the a 1 □Yes 2 □ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has but director, page 2 st autopsy performed 2 No 2 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA မ this funeral 28a. Date of Injury (Month, Day, Year) 27. Manmer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title7of certifier 29c. License number 29d. Date signed (Month, Day, Year, Baltimore, Maryland 21218 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5x State

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	of Maryland / [				Mental Hyg	iene	
			1 - State Registrar		Cer	tificate of l	Death	Re	eg. No.	19979
	Physici	an	1. Decedent's Name (First, Middle, Last)	1 -				2. Date of Death	Day Yea	3. Time of Death
No.	/Medic	al	Gladys Willey Mil  4a. Facility Name (If not institution, give street and n			4b. City, Town, or	Location of Death		25 2011 4c. County of De	9:25 p. M
	Examin	er	Mallard Bay Care Cer				mbridge			hester
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bit		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 16,	Year) 9. B	irthplace (State or Foreign Country)
	Director		213-22-7279 Usual Residence of Decedent	85	Yrs.			May 16,	1926	laryland
5	yland Iow		10a. State 10b. County	10c. City, Tow	n or Loc	ation				10d. Inside City Limits
$\mathcal{Z}$	a-fsh	ctor	MD Dorchester			C	ambridge			1 AYes 2 No
3	h with th	Funeral Director	10e. Street and Number 409 Leonard Lane			10f. Zip Code	21613	1	0g. Citizen of What 0	•
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercitant must be notified at	þ	Armed I	s 2 🙀 No Give	If	/as Decedent of H Yes, specify Cuba □Yes 2 <b>K</b> No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ar Black, Wh Specify:	nerican Indian, ite, etc. white
5-0	72 ho	etec	15. Decedent's Education (Specify only highest grade completed		(Give k	ent's Usual Occup	durina most of wor	king I	16b. Kind of Busines	s/Industry
121	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) College	(1-4or 5+)		ONOT use retired seamstres	_		garme	nt mfg.
d 2	ifiled I Hygi other ent, I	BeC	17. Father's Name (First, Middle, Last)					ne (First, Middle, M		
/lar	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Inc. M.	년 B	Frank Willey				Mary	Lawson		
Maryland	12 sho h and 7 Is mi raum		19a. Informant's Name/Relationship (Type. Print)  Lois Baker		,	Address (Street .) Box 58			City or Town, State	, Zip Code)
6	1 and Healt lem 2		20a. Method of Disposition			ition (Name of atory or other place	<u> </u>		21677 20c. Location - City (	or Town, State
E G	Pages ent of nt: If ii		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	n State		atory or other plac Mem. Pa		31/11	Cambridge	- MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra once.		21. Signature of Funeral Service Licensee	pozone					eral Home	
-	lmp any any		I gh w's tomen		1 /	00 Locus	t St., C	ambridge	, MD 2161	.3
1	Physician		23a. Part 1 Inter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition	each line.					est,	Approximate Interval Between Onset and Death
de	/Medical Examiner		resulting in death)  Due to	o (or as a consequence	of):	la a	. 12			
		Je.	Sequentially list conditions, in any, leading to immediate b.	o (or as a consequence	Oij.	) eme	<i></i>			
	icate be executed physician and the burial-transit	Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.							
8760,	be exe ician a burial-	E E	resulting in death) Last Due to	o (or as a consequence	of):					
		edical	d							
O. Box	at the death certifi by the attending tached for use as	Physician/Me	in the past 12 months?	outcome of pregnancy e birth 2  Fetal death egnant at time of death known		Ectopic pregnance Other (specify)	у		23d. Date of o	delivery Day Year
S, P.	s that t ned by s detac	by Ph	Part II. Other significant conditions contributing to	death but not resulting i	in the un	derlying cause give	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
ords	w requires been sign should be	ed b						1 □ Y€	es 2 1 1 10 3 1	Probably 4 Unknown
Vital Record	e la has	Completed						24a. Was a autops perforr	v Drior t	autopsy findings available o completion of cause of
		e Co	25. Was case referred to medical				00 Di	1 □ Yes	2 ☑ No 1 □ Y	es 2 4No
Š	S S =	To Be	examiner?	☐Inpatient 2☐ER/O	utpatient	3 □ DOA Oth	OF:	ath <i>(Check only on</i> Iome 5 ☐ Reside	<i>e)</i> ence 6 □Other <i>(S</i>	necify)
	After	tion: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		Time of Injury	28c. Injur Work	y at		ow injury occurred	
	al or Attending s after death. Il Director: Afte d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be	ce of Injury - At home, fa Iding, etc. <i>(Specify)</i>	arm, stre			28f. Location (St City or Town		Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (	29a. Certifier (Check only one)  1 CertifyIng Physician: To t 2 Medical Examiner: On the and ma							
_	To the He within 24 To the Fu	Me	29b. Signature and title of certifier	110		29c. Licens			9d. Date signed (Mo	
	1		Name Y	MU			4792		5.27.	2011
_	V\		30. Name and address of person who completed ca		(Type, P	rint) IRN ST	CAL	BRIDA	E MD	2/6/3
	Sta Registr		31. Date filed ( <i>Month</i> , <i>Day</i> , <i>Year</i> ) 32.	Registrar's Signature	bo	Med				

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1	For State Registrar		State of M	arylan		artment of ertificate of			Mental Hy	gien Reg. N		
					ne (First, Middle, L	ast)						2. Date of De	ath	201	3 Time of Death
	Physi Me	cian. dica		Blanche I	Elizabetl	n Mihill						Month May	27,	2011_Year	2:15 PM
	Exar			a. Facility Name (i	if not institution, gi	ve street and number)			4b. City, Town	, or Lo	cation of Death	)	4	c. County of Death	n
	-/		9	Suburban	Hospita:				Bethes					ontgomer	
	Funer Direct	_	- 1	Social Security N		Sex 7. Ag		ast birthday) Yrs.	If Under 1 Ye Months Day		f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 30		9. Birti	hplace (State or Foreign intry) nklin, NC
		or H	-	sual Residence o			96	1101				May_30	, 1	914   Frai	nklin, NC
	land show d at		1	Da. State	10b. County		10c. Cit	y, Town or L	ocation						10d. Inside City Limits
	Mary 28a-f otifie	1 2		MD	Montgome	ery	Che	vy Cha	ase						1 X Yes 2 ☐ No
	h the	15	10	De. Street and Nu	mber				10f. Zip Cod	9			10g. C	Citizen of What Cou	untry?
	th with ms 23 must	Totocial Icacan	1		es Mill I	7			20815					USA	
	r dear	Į į		1. Marital Status	ried 2 🗆 Married	12. Was Decedent Armed Forces? 1 Yes 2 X		S.   13.	Was Decedent of If Yes, specify Co	f Hispa Jiban, N	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White	
036	s afte al", c	yd botolethy	2	3 X Widowed		If Yes, Give Year or Dates.	No		1 🗆 Yes 2 🔀	No S	Specify:			Specify: Wh	nite
- C	hour natural	1		/C ==	15. Decedent's ecify only highest of	Education		16a. Dece	edent's Usual Occ	upatio	on	1.1	16b.	Kind of Business I	
2	in 72 nin 72 ne. han "	1 8	<u> </u>	Elementary/Sec	conday (0-12)	College (1-4 or :	5+)	life. I	kind of work dor DO NOT use retire	ed)	ng most ar won	King			
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, un	ntal H ed of	100	٠ i	7. Father's Name Charles ]	(First, Middle, Last	)						ne (First, Middle,	Maider	n Surname)	
<u> </u>	d Med Mark mark		- 1		lame/Relationship	(Time Orint)		E		_	ebecca		0		0.11.07075
Maryland 21215-0036	2 shouth and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and the and t	Ì	- 1			v / Daughte	r	1						or Town, State, Zip	Code) 37075 N ville, TN
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ď	a Tope	o	ł	Gay	Se 1	Copy Rogers			Gasch's	Fun	eral Ho	me, P.A			le, MD 20781
			2			mplications that caused one cause on each line		h. Do not en	ter the mode of d	ying, s	such as cardiac	or respiratory ar	rrest,		Approximate Interval Between
	Physicia	n/		mmediate Cause	(Final			ritis						.(	Onset and Death
	Medic Examin	_	ľ	esulting in death)		Due to (or as									·
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91419	cate be executed physician and sthe burial-transiti	edical Examiner	į	hat initiated event esulting in death)	ts	c. Due to (or as	a consequ	uence of):							
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3760				FEMALE		- 4.									
0. Box 68	Attending Physician: The law requires that the death certific releath.  stoor After this certificate has been signed by the attending is yithe funeral director, page 2 should be detached for use as	hy Dhyeirian/M	2	FEMALE: 3b. Was decedent		23c. If yes, outcome	of pregna	incy	☐ Ectopic pregn	ancv			-	23d. Date of deli	ivery
L 8	death he att ed for	:0		in the past 12 1  Yes 2 9  Unknowr	X No	4 Pregnant a			Other (specify,					Month	Day Year
0	that the dealed by the a	셤	P		-	contributing to death t	nut not res	ulting in the	underlying cause	niven	in Part I	220 Did t	chacen	usa contributa to	the cause of death?
5-0.	v requires that s been signed to should be deta					and the second		aning in inc	and onlying sauce	9					robably 4 🗆 Unknown
rd	requi been shoulk	o to	1									24a. Was			copsy findings available
	e law e has ge 2 s	Completed	-									auto		prior to c	completion of cause of
	ician: The la certificate ha rector, page			5. Was case refer	red to medical	Т			26	Place	of Death (Chec	1 🗆 Yes			2 🗖 No
Vita	ysician: is certific director,	la c	1	examiner? 1 \square Yes 2		Hospital:	ient 2 🗆	EB/Outpatie		ther:			dence	6 ☐ Other (Speci	(6.1)
2 5	ding Phys h. After this funeral di	١	2	7. Manner of Deat		28a. Date of inju	ıry	28b. Time of injury	of 28c. In	jury at		28d. Describe			197
0) 8	endin sath. or: Aft	1		1 X Natural 2 Accident	5 Pending Investigati	on	y, real)	ii ijai y	M 1	ork?	s 2 🗆 No				
Che Mini   E	or Atter fter de irrector	Cortificato.		3 ☐ Suicide 4 ☐ Homicide	6  Could not determine				reet, factory, offic	e		28f. Location (		nd Number or Run e)	ral Route Number,
Blanche Mithil	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this: completed filled in by the funeral dir	100	-	0.00	1501 o										
K	Hos 24 ho Fune eted f	ledical	2	(Check 2	2 Medical Exa		examination	n and/or inve	stigation, in my op	inion, d	death occurred a	at the time, date	and plac	e, and due to the c	cause(s) and manner stated.
$\widetilde{\Omega}$	To the vithin o the	2		only one) 3 9b. Signature and		rse Practioner: To the	pest of my	y knowledge,	death occurred a			ice, and que to th		e(s) and manner as a ate signed (Month)	
-	F > F 0			•	dum	47.	. ) .		D37	891				27, 2011	
	2 1		3	D. Name and addr	ress of person who	completed cause of c	leath (Item	1 23a) (Type,							
CA						21 Congres	sion	al Lar	ne, #409	, R	ockvill	e, MD 2	085	2	
		tate	3.	UN 0 1	th Day Year)	32. Figistr	ar's Signat					111-221			
	Regis	strar		JUNU A	LUIT JUST	1.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Harry Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland 8. Date of Birth (Month, Day, Year) May 11, 1931 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Piedmont, WV 234-62-4671 80 Director Usual Residence of Decedent show 10d. Inside City Limits . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. It attr. If if item 27 is marked other than "natural", or items 23a or 28a-f sho iury or orler traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 26726 Rt. 4, Box 593 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc 1 
Never Married 2 
Married þ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Year or Dates. 1952-54 Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Viola S. Dawson James W. Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rt. 4. Box 593 Keyser, WV Lena F. Martin/Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Potomac Memorial Gardens Keyser, WV . Signatural Service License 22. Name and Address of Facility 85 S. Main Street Smith Funeral Home Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onse and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner BO AR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: s been signed by the attendi-should be detached for use yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 2 🗌 No g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 300E 1 🔲 Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy director, page 2 performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**o မ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending 1. Natural work? 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) NE 84 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21502 Robert Welik, M.D. 904 Seton Drive Cumberland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

4 2011

11-04186 Ellen McCardell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

illeri McCarder		1- For State	e of Maryland /	-	ιπment of tificate of		iu ivientai		20	1888			
Physic		1. Decedent's Name (First, Middle,L	_ast)					2. Date of Dea		3. Time of Death			
Medical Exam	ine		Ellen Edith	McCa				June 3, 2		1820 hrs			
		<ol> <li>Facility Name (if not institution, 272 Hollingsworth Mano</li> </ol>			4	b. City, Town, c Elkton	or Location of De	ath	4c. County of D	eath			
Funeral		Social Security Number 6.	Sex 7. Age	(In yrs. la	ast birthday)	If Under 1 Ye	ar If Under 24	Hrs. 8. Date of B	irth(MM/DD/YYYY) 9	. Birthplace (State or preign New York			
Director		136-56-1746	M 2∑F 5.	3	Yrs.	Months Da	ys Hours N	Min. 03/23	3/1958 F	oreign NEW YORK Country)			
kas		Usual Residence of Decedent 10a. State 10b. County	1	Oc City	Town or Location					10d. Inside City Limits			
	Ĺ	Maryland Kent	İ		alena	,,,				1 X Yes 2 No			
Maryland 28a-f show d at once.	Director	10e. Street and Number			Tella	10f. Zip Code			10g. Citizen of What	Country?			
with the Maryland ns 23a or 28a-f sho be notified at once	ä	114 West Cross	Street			2163	5		United	States			
th with	Funeral	11. Marital Status 1 Never Married 2 X Marri	12. Was Decedent B Armed Forces?	ver in U.			lispanic Drigin? ( an, Mexican, Pue	Specify Yes or No	o- 14. Race - A White, et	merican Indian, Black, c.			
ter dea			1 Yes 2	X No	1	Yes 2 X N	o specify:		Specify: [	√hite			
ours af aturali camin	d by	15. Decedent's Education (Specify	or Dates:	leted)	16a. Decedent	s Usual Dccupa	ation (Give kind		16b. Kind of Busine				
16 n 72 h uan "n ical Es	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5	-)	-		e. D <b>D N</b> DT use r	retired)					
-003 1 withi 1 giene.		17. Father's Name (First, Middle, La	2 (st)		Home	maker	18 Mother's Na	me (First Middle	In Her	Own Home			
21215-0036 wild be filed within ? Mental Hygiene. marked other than	BeC	Charles F. Pens	•					Evelyn 1	•				
221 hould I is man	²	19a, Informant's Name/Relationship					et and Number o	or Rural Route Nu	mber, City or Town, S	tate, Zip Code)			
, MD and 2 sho calth and cm 27 is		James J. Baran, 20a. Method of Disposition	Jr./Son	20b. F	87 Ye.			,	Lkton, MD 20c. Location - Cit	21921			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menell Hygient Department of Health and Menell Hygient Emportant: If tiens 123 or 23s.f she injury or other traumatic event, the Medical Examiner must be notified at once		1 Bunal 2 X Cremation		e c	rematory or other	er place)	Jı	une 7,					
altin nit. Pa Partmen Portan		4 Donation 5 Other Speci 21. Sig ature of Funeral Service Lice		I.	A. Ferris	me and Addres			West C	hester, PA			
E E E	105 W. Stockton Street, Eikton, Fil												
Physician /Medical													
Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cocaine and Narcotic Intoxication (Fentany) and Oxycodone)  Due to (or as a consequence of):											
		Sequentially list conditions,	b										
	nine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consec c.	uence of	):								
pe ed	Examiner	events resulting in death) Last	Due to (or as a consec	uence of	):								
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Medical	X UNPENDED	d. AMENDED 23a	27.2	28a-f.pe	er me.g	916 6-17	7-11 sm					
'60, ate be ex physician	Med	IF FEMALE:	23c. If yes, outcome						23d. Date of deli	very			
Box 6876 death certificat he attending ph d for use as the	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at ti	me of dea	ah -		Ectopic preg	nancy	Month	Day Year			
Box e death the atte	Physician/	1 Yes 2 No 9 ✔ Unknow			oth 5 Dthe	er (Specify)							
P.O. es that the gned by the detache	by Pi	Part II. Other significant condition:	contributing to death	out not re	sulting in the un	derlying cause	given in Part I.			to the cause of death?			
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Vita ysicia nis cer directo	o Be	examiner?	Hospital: 1 Inpatient	2 🔲	ER/Outpatient		Other		Residence 6 🗸 0	ther: Scene			
Of Of After the truncal	n: To	27. Manner of Death	28a. Date of Injury (Month, Day,Yea	r)	28b. Time of Inj	· I _ ·	ury at Work?	1	how injury occurred				
Sion Attendi death. ctor:	atio	Natural 5 Pending Accident Investiga	ation IU 0-3-1		fd 5:45	РШ	Yes 2 X No	Unknown					
Division of Vital   Bospital or Attending Physician: 24 hours after death. (*meral Director: After this certificity filled in by the funeral director.	Certification:	3 Suicide 6 X Could no determin				factory, office I	building, etc.	or Town, S	tate)272 Holli	Rural Route Number, City  ngsworth Manor			
e Hospit 124 hour e Funeri letely fill		4 Homicide  29a. Certifier (Check only 1 Certifying Physics)	ician: To the best of my			d at the time, d	ate and place, a	Elkton,		stated.			
Divis  To the Hospital or A within 24 hours after To the Funeral Dire	Medical	one) 2 Medical Examin	er:On the basis of exami and manner stated.	nation an	d/or investigatio	n, in my opinior	n, death occurred	d at the time, date	and place, and due to	the cause(s)			
	Σ	29b. Signature and title of certifier				29c. Licens			29d. Date signed (	Month, Day, Year)			
		1 limby Truthe	ull, mi	4h /4 -	22-1		M.E.		June 4, 2011				
	Į. )),	30. Name and advess of person who Pamela E. Southall, MD	Assistant Medic	,	,	W. Baltimor	e Street, Bal	ltimore, MD 2	1223				
	ate	31. Date they (Months Day Year)	32. Registrar				-						
Regis	rar	AAH T 7 7011	warmen by	CI									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Paul Phillip Nunnally Gene Medical May 2011 9:30 Α 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Williamsport Nursing Home Williamsport Washington 5. Social Security Numbe 8. Date of Birth
(Month, Day, Year)
Feb. 6, 1932 9. Birthplace (State or Foreign Country) Michigan . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** XX_{M 2} □ Months Hours 295-24-3117 79 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland 1 Yes 2 XNo Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 11028 Celeste Drive 21795 USA hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 19 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 X Married 1951 Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced 1957 Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Medical Equipment Specialist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Nunnally Hope Elizabeth Keating 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Nunnally - Wife 11028 Celeste Drive Williamsport, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Dopation 5 DO Other (Secify) Hagerstown Crematory June 1,2011 Hagerstown, Maryland 21. Signature of Funera 5 Osborne Punerally Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ZH HOURS PHEMMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner DAYS DYSPHAGIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last MULTIPLE CEREISRAL INFARCTO Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 U Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law page 2 s this certificate has autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After (Month, Day, Year) 1 Natural 5 Pending work' within 24 hours after death To the Funeral Director: A 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29c. License number son who completed cause of death (Item 23a) (Type, Print) ARTIZAN

DHMH 17 Rev 7/2009

Registrar

JUN N 🛭 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 Physician/ 10:48 M CARROLL PARLON 2011 ATRICIA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY MONTGOMERY GENERAL HOSPITAL DLNEY If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Country) D.C. Year) 193<u>5</u> (Month, Day Yo 1 ☐ M 2🏝 Months Days Hours Nov. Director 579-48-0421 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10a State 10c. City. Town or Location aţ Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified 1 Yes 2X No Rockville MDMontgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 20853 13123 Beaver Terrace death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. Yes 2 X No Yes, Give þ 1 Never Married 2 Married 72 hours after altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3

™ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland permit. Page 1 and 2 should be file peartment of Health and Mental I Important: If item 27 is marked or any injury or other traumatic eve ည Bernardine J. Lesher John L. Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13123 Beaver Terrace, Rockville, MD 20853 Janis Parlon/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date May 23 2011 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen-Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Oue to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending when the funeral director manner of the funeral director manner. Exam Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 No 1 Yes 1 Yes 2 🗗 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 2 🖾 No 1 Yes 1 Inpatient 2 FR/Outpatient 3 DOA ျ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and litle of certifier 29c. License number 22, 2011

State

Registrar

00060319

18111 PRINCE PHILIP DR, OLNEYMO 20832

MO

3. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAMMER

MAY 24 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 8:25A.M Mary Louise PLANK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reeders Memorial Home Boonsboro <u>Washington</u> Social Security Numbe 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours July 29 ^{Year)}923 Maryland 87 Director 214-54-0232 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director 1 ☐ Yes 2 🛣 No Washington Maryland| Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18728 Wagaman Road 21740 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working n and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 Homemaker Her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Beckley Mary Pearl Harsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) copartment of Health an Important: If item 27 is any injury or other training. <u>Edwin L. Plank - Son</u> 9423 Garis Shop Road, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Salem Reformed Cem. 6/4/2011 Hagerstown, Maryland 21. Signature of Juneral Service 22. Name and Address of Facility Minnich Funeral Home "Elles 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Ener Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 9 Unknown Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has dine ₽ No 1 Yes 2 No Yes 25. Was case referred to medic. 26. Place of Death (Check only one) 10 Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred hours after death. Natural Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation filled in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventional in the control of the cause of examination and/or inventional in the cause of examination and/or inventional in the cause of examination and/or inventional in the cause of examination and/or inventional in the cause of examination and/or inventional in the cause of examination and/or inventional in the cause of examination and or inventional in the cause of examination and or inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional inventional invent Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis or examination arror investigation, it my spinior, seal of the cause (s) and manner as stated at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certif 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301-733-4496 580 NORTHERN AVENUE, HAGERSTOWN, MARYLAND 21742 SHAHID MAHMOOD, 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#23 openMD, 5/26/11; BWW, MoCo Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician/ DWHRD May 2011 7:00 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Saint Thomas More Nursing Facility Hyattsville Social Security Number 6. Sex 8. Date of Birth (Month, Day, Y Dec. 18, 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Hours 1 M 2 D F 237-50-5834 80 **Director** Dec. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director Prince Georges 28a-f Maryland Bladensburg 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 5300 Newton Street Funeral Apt. 212 20710 U. S. A. items 23a ner must l 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc à 1 Never Married 2 Married Yes 2 X No Yes, Give Maryland 21215-0036 filed within 72 hours after 1 Yes 2 K No Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Restaurant the Cook Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) မ John Wesley Ramey Maude Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5330 Colorado. Avenue, N.W. #303 Washington, D. C. 20011 Lee Ramey (Nephew) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National 05/25/2011 Suitland, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
W. H. Bacon Funeral Home Inc
3447 14th Street, N.W. Washington, DC 20010 23a. Part 1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Interval Between Immediate Cause (Final Merosderlie Onset and Death Physician/ Cardinascular disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that is interested as exercised.) Due to (or as a consequence of) attending physician and for use as the burial-lansit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALEMOVE TIEM 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month signed by the a Yes 4 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? certificate 1 Yes 2 No Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home this 5 Residence 6 Other (Specify, 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of within 24 hours after death.

To the Funeral Director: After t completed filled in by the funera 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🔲 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of a 29c. License number **5** 29d, Date signed (Month, Day, Year) 15 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajit Kurup, M.D. 4922 LaSalle Road 20782 Hyattsville, Md. 31. Date filed (Month, Day, Year, State MAY 24 2011 Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

(ariei Rashad Rol	1	- For State	ate of	Marylan		artment of		and	Menta	al Hyg		Reg. No.	0 1	1 18881
Physician		t <b>egistrar</b> 1. Decedent's Name (First, Mido	le,Last)		-					2	2. Date of Dea Month	ath	ear	3. Time of Death
Medical Examine						i Robins					May 20, 2	2011		1047 hrs
di.	ď	4a. Facility Name (if not institution 1 Backbone Road, M	. •			I .	b. City, Tow Princes:	,		Death		4c. County Somers		h
Funeral		5. Social Security Number	6. Sex		Age (In yrs. la		If Under 1		if Under 2	24Hrs.	8. Date of B	rth(MM/DD/YYY		thplace (State or
Director	ı	166-74-7308	1 X M			20 Yrs.	Months	Days	Hours	Min.	10/28	/1990	Foreig	gn puntry) PA
,	h	Usual Residence of Decedent	1[26]	<u></u>			11							
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the Maryland n or 28s-f sh		10e. Street and Number	1 100	<b>0</b> 4 i	#200		10f. Zip Co		20770			rog. Citizen or v	u.s	
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leath v	3 I	1 X Never Married 2 N	arried 1	Armed Ford	es? 2 X No		es, specify C					Whi	ite, etc.	-American
	Ç -		orced If Ye	es, Give Yeer Dates:			Yes 2 χ							-American
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MD 21 d 2 should th and Me a 27 is ma umatic ex	- 1	19a. Informant's Name/Relation: CLeopatra J. Ro			athor		,					mber, City or To Gภออทธิอ		MD 20770
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Baltimore, permit. Pages 1 a Department of He Important: If it it injury or other the		4 Donation 5 Other S  21. Signature of Funeral Service	Licensee			22. N	ame and Ad	dress of	f Facility H	line	s-Rina	ldi Fun	eral	n, SC Home, Inc. ing.MD 20904
E F D B W		alay	1, 10	om										
Physician //weaical	ď	23a. Part I. Enter the disease of failure. List only one cause	n each lii	ne.							espiratory ar	rest, shock, or h	eart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)			due to	o inhal	ation	of	hell	ium				Death
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		if any, leading to immediate cause. Enter Underlying Cause	Due	to (or as a co	onsequence of	f):								
nsi (		(Disease or injury that initiated events resulting in death) Last	c. Due	to (or as a co	onsequence of	f):								
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ath cert	2	past 12 months?  1 Yes 2 No 9 Un	known d	=	t at time of de	ath 5 Oth	er (Specify)	)				1		4 3
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Division of Vital Records, P.O. Box 68760.  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the becampletely filled in by the funeral director, page 2 should be detached for use as the beautified.		0 0 00	hysicien: 'miner: On	To the best of	of my knowled	ge, death occur nd/or investigat	ed at the tim	ne, date pinion, d	and place leath occu	e, and d	ue to the cau	ise(s) and mann	er as stat	ted.
To To t	2 2	29b. Signature and title of certifi	and	manner stat	ed.	· · · · · · · · · · · · · · · · · · ·		icense r		•				onth, Day, Year)
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	3	80. Name and address of person	who comp	leted cause	of death (Item									
		Melissa Brassell, MD	Assis		cal Examir			re Stre	eet, Bal	timore	e, MD 212	23		
Stat Registra		31. Date filed (Month, Day, Year)	011	Regi Registr	strar's Signat	face fork	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hester Bernice Roberts May 23, 2011 1:35A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8708 Fort Foote Rd. Ft. Washington Prince Georges Social Security Number 8. Date of Birth (Month, Day, Year) May 17, 1916 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Hours 579-24-1013 Director 95 Yrs. BowlingGreen, VA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Prince Georges Ft. Washington 1 🗆 Yes 2 🏝 No 10f. Zip Code 10g. Citizen of What Country? by Funeral 8708 Fort Foote RD. 20744 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2X No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami Black 1 Yes 2 XNo Specify: 3 → Widowed 4 □ Divorced If Yes, Give Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John W. Mont Lucy В. Page 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saundra Stevenson/Daughter 8708 Fort Foote Rd. Ft.Washington,MD 20744 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) May 28,2011Bowling Green, VA Evergreen Cemet. Signature of Funeral Service Licens Genesis Cremation And Funeral Services 5732 GA., Ave., NW Washington, DC 23a. Part 1. Effer the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on some of hine. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exami death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-t Completed by Physician/Medical Box 68760 the attending plant IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year signed by the a d be detached f 1 Yes 2 9 Unknown 2 X No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertention, Chronic Bronchitis Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician; The I within 24 hours after death.

To the Funeral Director; After this certificate h completed filled in by the funeral director, page performed? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1X Yes Other: 4 \(\sum \) Nursing Home 5 \(\overline{\pi}\) Residence 6 \(\sum \) Other (Specify) ဂ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Continue Physician: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

MAY 27

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugenio Machado, MD 3110 Gracefield Rd.

D24035

Silver Spring, MD

May 26, 2011

18888 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Physician/  $\overset{\text{Year}}{2011}$ 1:50PMM James Theodore Rice May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice Center of Queen Anne's Centreville Queen Anne's 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 10/10/1928 Director 194-20-8456 Pennsylvania 82 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City. Town or Location should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 No Beaufort Hilton Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29926 57 Big Woods Drive USA ral", or items ? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. þ 1 Never Married 2 Married Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 ₩Widowed 4 Divorced Year or Dates. ed other than "nature event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Engineer Industrial Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles Janet Louise McPhilimy Rice 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 s Department of Health Carolyn Culp / Daughter 112 Recovery Drive West Centreville, MD 21617 item 2 other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 5/28/201
Chesapeake CremationCenter LLC 20a, Method of Disposition 20c. Location - City or Town, State 5/28/2011 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stevensville, MD 22. Name and Address of Facility
Fellows, Helfenebin & Newnam Funeral Home, P.A.
408 South Liberty Stret Centreville, MD 21617 21. Signature of Juneral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BILLAT Physician/ CANL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami death certificate be executed Cause (Disease or iinjury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Vear Pregnant at time of death ate has been signed by the page 2 should be detached Unknown 9 Unknown that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsv death? certificate 1 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🗷 No Other: HOSPILL 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Nother (Specify) Levid 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. injury work? 1 ☐ Yes 2 ☐ No 1 M Natural 5 Pending Accident Investigation Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide filled in by determined City or Town, State To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) entreville RD Contreille VILENS 2540 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2<u>011</u> Physician/  $\mathbf{P}$  M MARGARET F. ROGERS MAY 23 5:15 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) AUG. 17, 1941 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Director MARYLAND 220-36-2013 69 Usual Residence of Decedent 28a-f show 10a State 10b. County ral", or items 23a or 28a-f shor Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No GRASONVILLE MARYLAND QUEEN ANNE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 120 RADCLIFFE ROAD UNITED STATES 21638 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ CHARLES KERNER CHRISTINE MYERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health in BERNARD DENNIS ROGERS/HUSBAND 120 RADCLIFFE ROAD, GRASONVILLE, MARYLAND 21638 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State CHESAPEAKE CREMATION CENTER 4 Donation 5 Other (Specify) STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A.
106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (Das a consequence of) Immediate Cause (Final Physician/ Ventric disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last burial physician the burial Physician/Medical death certificate be Box 68760 attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 2 No ed by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vascald Records, 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Diabelis Mellita 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h performed 2 🗆 No Yes 2 No 1 Tes 25. Was case referred to nedical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital 1 Tes ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending after death. 1 Yes 2 🗌 No 2 Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) D08058297 Name and address of person who completed cause of death (Item 23a) (Type, Print) MO Annedrundel ours GSTAWONS 32. Registar's Signature

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25,^D2/011 Mary Lillian Ravdin 4:45a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Washington Rockville Montgomerv 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth Funeral 6. Sex 7. Age (In vrs. last birthday) Days Min New York 1 □ M 2 🛭 I 9/19/19/18 92 Director 577-18-4158 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Rockville MD Montgomery 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 USA 6121 Montrose Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l th and Mental Hygiene. ?7 is marked other than "r Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Richmond Lamp Co. Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Marsel Hyman Greenburg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $\,22408\,$ 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shr Department of Health an Important. If item 27 is any injury or other trausonce. Kay Ravdin/Daughter 4811 Queensbury Circle Fredericksburg, Va 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal/from State 5/27/2011 Richmond, Va. Richmond Bethel 4 Donation Other (Specify) 21. Signature of Fun ral Service License Phiangapage Andes Richard Funeral Service, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ UTE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Ectopic pregnancy Month Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 XNo Division of Vital Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe Yes 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

26 2011

1/AN

AV

30. Name and address of person who completed cause of death (Item 23a)/(Type, Print)

62. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 2011 Joseph Matthew Romanek 1123 AMMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Union Hospital E1kton Cecil. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Days Hours March 19 Year) 1945 Director Maryland 213-44-7942 66 Usual Residence of Decedent or 28a-f show 10a. State If than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 311 Hermitage Drive 21921 United States 12. Was Decedent Ever in U.S Armed Forces? 196 1 K Yes 2 \sum No If Yes, Give 196 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1962-Black, White, etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Sandwich/Pizza Shop Be th and Mental H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Joseph Romanek Roselena Sacconev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melba I. Romanek/Wife 311 Hermitage Drive, Elkton, MD 21921 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State June R. A. Ferris & Co., Inc. 4 Donation 5 Other (Specify) 2011 West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Myocarchal Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician a sthe burial Physician/Medical Box 68760 as IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Day 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes mellotis Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ongestive Heart performed? Yes 2 N death? 2 🗌 No Hospital or Attending Physician: **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ပ 1 Inpatient 2 R/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending s after death. 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier соmpleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the P within 2. 29d. Date signed (Month. Dav. Year) D0053675 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 W. High St. Sute 214, Elkton MD Monteleone, M.D. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

11-04076 Jeffrev Lynn Rowe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

eπrey Lynn κοι		1- For State Registrar	State of Mary	•	rtificate of		nu went		2 (1 ) l eg. No.	18892
Physicia Medical Exami	an/	Decedent's Name (First, N		Jeffrey 1	Lunn Row	e		2. Date of Deat Month May 31, 20	h	3. Time of Death 1854 hrs
neulcai Exami	iiei	4a. Facility Name (if not insti				b. City, Town,	or Location of		4c. County of Deat	
		12445 Gateway Av		Table 0		Hagerstov		Odlar To Date of Bid	Washington th(MM/DD/YYYY) 9. Bit	dhalass (State or
Funeral Director		5. Social Security Number 219-72-8398	6. Sex	7. Age (In yrs.	Yrs.	If Under 1 Ye	ear If Under ays Hours	Min	Forei	
any	ŀ	Usual Residence of Deceder 10a. State 10b. Cou		10c. City	, Town or Location	on				10d. Inside City Limits
Maryland 28a-f show i at once.	5		Washington				Hagerst			1 Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 12445 Gate	eway Ave.			10f. Zip Code 2 1	1740	11	0g. Citizen of What Cou $U \cdot S \cdot A \cdot$	intry?
or iter	Funeral	11. Marital Status 1 Never Married 2			If Ye		an, Mexican, F	n? ( Specify Yes or No- Puerto Rican, etc.)	White, etc.	rican Indian, Black,
urs afte tural" amine	d b	3 Widowed 4 X  15. Decedent's Education	or Dates:		16a. Decedent	's Usual Docup	oation (Give ki	ind of work done	16b. Kind of Business	
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0	-12) College	e (1-4 or 5+)	during mo	st of working li Pair		ise retired)	Constru	ction
5-00 lled wit Hygien other		17. Father's Name (First, Min					18.Mother's	Name (First, Middle, M	Maiden Surname)	
2121 Mental Marked event,	To Be	William  19a. Informant's Name/Relai	L. Branch		19b. Mailing	Address (Str	eet and Numb	Anna Rowe per or Rural Route Num	ber, City or Town, State	e, Zip Code)
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. n 27 is marked other than umatic event, the Medica	-	Skylar L. Ro			20 S.	Potoma	ac St.	Apt. B Way	nesboro, P	A 17268
s l anof Heal		20a. Method of Disposition  1 Buria! 2 X Crem  4 Donation 5 Other		I from State	Place of Disposit crematory or oth thsburg	er place)		Date June 5, 2011	20c. Location - City of Smithsburg	g, Maryland
Baltimo permit. Page Department o Importent: injury or oth		21. Signature of Funeral Ser	rvice Licensee	MO 14	£ 1 4	ame and Addre	_		vis Funeral	
Physician	2	22a Fart I. Enter the diseas	e, or complications the							Approximate Interval Between Onset and
/Medical Examiner		failure. List only one ca Immediate Cause (Final disc or condition resulting in dea	ease a. Hanging	is a consequence	of):					Death
		Sequentially list conditions,	b							
	Examiner	if any, leading to immediate cause. Enter Underlying Ca (Disease or injury that initial	ause	is a consequence	of):					
cuted nnd transit	I Exar	events resulting in death) L		is a consequence	of):					
60, te be executed sysician and burial - transit	Medical	UNPENDED	AMENDE							
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and applietly filled in by the funeral director, page 2 should be detached for use as the burial. transit		IF FEMALE: 23b. Was decedent pregnant past 12 months?	t in the	es, outcome of preg e birth egnant at time of d	2 Fet	al death	3 Ectopic	pregnancy	23d. Date of deliver Month	ry Day Year
O. B. It the de by the ached f		Part II. Other significant co	3 01	known g to death but not	resulting in the ur	nderlying caus	e given in Par	t I. 23e. Did to	bacco use contribute to	the cause of death?
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of Vital Records, F ng Physician: The law requires i After this certificate has been sign nneral director, page 2 should be e	Completed							24a. Was autop	sy prior to rmed? death?	utopsy findings available completion of cause of
tal Rec		25. Was case referred to me	edical			26.Pla	ace of Death (	1 Yes Check only one)	2 No 1 Y	es 2 No
Vita	To Be	examiner?  1 ✓ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient		TOWNS		Residence 6 🗸 Othe	er: Scene
n of ading Ph		27. Manner of Death	Pending FOU	ate of Injury onth, Day,Year) ND:	28b. Time of In FOUND:	njury 28c. Ir	njury at Work? Yes 2 ✔	Subject han	how injury occurred ged self	
Division rs after death.	Certification:	2 Accident 3 Suicide 6	Investigation May Could not be May	31, 2011 Place of Injury - At I	1853 hrs home, farm, stree	t, factory, office	e building, etc	or Town, S	state)	ural Route Number, City
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To the Hos within 24 hd To the Fun completely	Medical	(Check only 1 Certifyii one) 2 Medical	I Examiner: On the base and mann	sis of examination	and/or investigati	on, in my opini	ion, death occ	curred at the time, date	and place, and due to t	he cause(s)
F 3 F 3	ž	29b. Signature and title of co					nse number		29d. Date signed (Me June 1, 2011	onth, Day, Year)
		Name and address of pe	erson who completed o	ause of death (Ite	m 23a)	0.0	. IVI. La.			
A. T. C. All Land Co.	7 29	Laron Locke MD.	Assistant Med	ical Examiner	900 W. Ba	Itimore Stre	eet, Baltim	ore, MD 21223		
S Regis	tate	31. Date filed (Month Dex.)	(ear) Seren 32	. Registrar's Signa	Wre Co					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 25, **20**11 6:45 A Gertrude Silverman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Montgomery Hebrew Home of Greater Washington Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Nov. 15 1 🗆 M 2 🖾 F ^CNeW York ^{ar)} 1915 95 Director 085-03-7510 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Rockville MD Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 USA 1621 Montrose Road 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: 3 X Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Bookkeeping Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Nettie "Unknown" Emil Yankowitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 Shagbark Court, Rockville, Maryland 20852 Roger Silverman/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crember are the place)
Memorial Gardens 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 5/26/2011 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of EdWard Sagel Funeral Direction, Inc. MCGHERHOO mo1597 091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter In Jerlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): an and To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been sirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2**V** No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) farli 5/25/2011 nunn Doo64871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 6121 Montrose Rd 2085 Fazli, MT 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Soorya Prasad Shah May 30 Medical 2:07 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrest Hospice Columbia Howard 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days Hours 1 🔀 M 2 🗆 F 545-55-8178 67 **Director** 03-23-1944 Nepa1 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD St. Mary's Great Mills 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22088 St. Michaels Circle 20634 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Asian Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation
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Registrar

DHMH 17 Rev 7/2009

State

DANIEUE

31. Date filed (Month, Day, Year)

OUBSERMAN, MO

32. Registra Signature

6336

CEDAR LANE COLUMBIA, MD 21044

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of M	aryland	•	artment of F tificate of E		,	_	2011	10005
			Decedent's Name (First, Middle,	Last)		00/	inoato or b	- Catir	2. Date of De			3. Time of Death
	Physicia Medio		Richard	Francis	S	hane			May Month	26 ^{Day}	2011	2:02 P M
7	Examin	er	4a. Facility Name (if not institution,	give street and number)			4b. City, Town, or	Location of Death		4c.	County of Death	1
	-		3929 4th Stree 5. Social Security Number		e (In yrs. lasi	t hirthday	North If Under 1 Year	Beach If Under 24 Hrs.	La Di (B)	_	Calvert	
	Funeral Director		518-38-0036 Usual Residence of Decedent	1 <b>X</b> M 2 □ F	77	Yrs.	Months Days	Hours Min.	8. Date of Birl Month Da 10/15/	1933	9. Birti Ida	nplace (State or Foreign ntry) NO
	and show	ō	10a. State 10b. County	-	10c. City,	Town or Loc	ation					10d. Inside City Limits
	Maryl 28a-f atifiec	rect	MD Cal	vert			North	Beach				1 🎇 Yes 2 □ No
	h the a or 2	a a	10e. Street and Number				10f. Zip Code			10g. Citi:	zen of What Cou	untry?
	th wit ns 23 must	<b>Funeral Director</b>	3929 4th Stree				20714				USA	
(0	or iter	y Fu	11. Marital Status 1 ☐ Never Married 2 🌠 Marri	12. Was Decedent B Armed Forces? ed 1 X Yes 2	Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	1	<ol> <li>Race - Amer Black, White</li> </ol>	
93	rs afte rral",	q pa	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		$\frac{1}{3}$	☐ Yes 2 🌠 No	Specify:		8	Specify: Whi	te
5-0	2 hour "natu	plet	15. Deceden (Specify only highes	's Education		16a. Deced	ent's Usual Occupa ind of work done de	ation	ina		nd of Business I	ndustry
121	e filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	Elementary/Seconday (0-12)	College (1-4 or 5		life. DO	NOT use retired)	J	nig		Air For	
d 2	filed within all Hygiene. d other that	Be (	12 17. Father's Name (First, Middle, La	st)		Telev	ision Tec	18. Mother's Nam	o /Eirot Middlo			vernment
<u>la</u> n	should be file n and Mental I 7 is marked o raumatic eve	To	Hardie	Shane	2			Frances		zabe	,	ampbell
ary	should and M is ma auma		19a. Informant's Name/Relationshi		-	19b. Mailin	g Address (Street a	nd Number or Rura			_	
≥,	1 and 2 sif Health item 27 other tra		Stella M. Shane	, spouse		P.O.	Box 447,			736		
Baltimore, Maryland 21215-0036	ge 1 and 2 should be nt of Health and Men I fitem 27 is marke or other traumatic		20a. Method of Disposition  1 N Burlal 2 Cremation 4 Donation 5 Other (Sp	3 ☐ Removal from State	20b. Plac	ce of Dispos netery, crem	sition (Name of atory or other place	a)	Date	20c. Loc	cation - City or T	own, State
Ħ	uit. Pag artmer ortant. njury	9			St.		' Parish		-2011		hian, M	
Ba	permit. Page 1 a Department of I Important: If its any injury or of	e e	21. Signature of Funeral Service Lie	R. Glo			Name and Address 325 Mt. H		ausch Fu ane, Ow			
н			23a. Part 1. Enter the disease, or of shock, or heart failure. List on	omplications that caused ly one cause on each line	the death. [	Do not ente	the mode of dying	, such as cardiac o	or respiratory arr	est,		Approximate Interval Between
	Ph_sician/ _ Medical	i l	Immediate Cause (Final disease or condition resulting in death)	a			itic 1	Nelar	roma.			Onset and Death
-jugan	Examiner			Due to (or as a	a consequen	ice of):						18 months
7		iner	Sequentially list conditions, if any leading to immediate	b. Due to (ur es a	повысонно	ine of):						
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	e exe	alE	resulting in death) Last	Due to (or as a	a consequen	ice of):						
2092	ath certificate be executed attending physician and for use as the burial-transit	edical Examiner		d							+	
89			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy	У					3d. Date of deliv	/en/
P.O. Box	death certif ne attending ed for use a	Physician/IV	in the past 12 months?  1  Yes 2 No	1 ☐ Live Birth :			Ectopic pregnancy Other (specify)				Month	Day Year
0	es that the des signed by the a l be detached f	Phy	9 Unknown	9 Unknown					1			
ς, σ.	In the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Completed by	Part II. Other significant condition	s contributing to death bu	ut not resulti	ng in the ur	deriying cause give	n in Part I.				he cause of death?
Division of Vital Records,	v requires been significations should be	lete							24a. Was a			psy findings available
ec :	he law te has age 2 :	mo			_				autop _ perfor	sy med?	prior to co death?	empletion of cause of
<u></u>	ian: T		25. Was case referred to medical				26. Plac	ce of Death (Check	1 L Yes	2 No	1 Yes	2 No
₹	hysic his ce Il direc	유	examiner? 1 ☐ Yes 2 No	Hospital:		/Outpatient	3 DOA Other	: 4 □ Nursing Ho	me 5 🗶 Resid	ence 6	Other (Specif)	0
יסל	ding Physician: The la h. After this certificate ha funeral director, page	ate:	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of injur (Month, Day,	y Year) 28	b. Time of injury	28c. Injury a work?	_	28d. Describe ho	w injury o	occurred	
Sion	death death ctor: y the	Certificate:	2 Accident Investiga 3 ☐ Suicide 6 ☐ Could no	ot be	n/ - At home	form stree		es 2□No	206		No.	(S. 1 N /
Σ	al or / s after l Dire		4 L Homicide determin	building, etc.		, iain, dice	st, ractory, office		28f. Location (St City or Town		Number or Hura	i Houte Number,
	lospit Hour unera	edical	29a. Certifier 1 Certifying P	hysician: To the best of r	ny knowledg	ge, death oc	cured at the time, o	date and place, and	d due to the cau	se(s) and	manner as state	ed.
-	the H thin 24 the F mplete	≥ ¦	only one) 3 L Certifying N	aminer: On the basis of ex lurse Practioner: To the b	pest of my kn	owledge, de	ath occurred at the	time, date and place	e, and due to the	d place, a cause(s) a	and due to the ca and manner as st	use(s) and manner stated. ated.
	<b>₽</b>		29b. Signature and title of certifier	Moroar	- A /	$\circ$	29c. License r	127189	2	9d. Date	signed (Month	Day, Year)
Ž		-	30. Name and address of person wh		1			21104			[-1]	2011
JRN	15+1		Zahir Yousaf, M				. Rd. Nor	th. Hunt	ingtown	_ MD	20639	
	State	-	31. Date filed (Month, Day, Year)	32. Registra	S Signature		Sparks	CII IIUIIL	-IIECOWII	1111	20039	
	Registra	r	MAY	31 ZUTT /	inun	p.	granke					

11-03872 Deana Martin Sine Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Deana Martin Sipe State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Medical Examiner 0142 hrs Deana May 24, 2011 Martin Sipe 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Frederick Calvert Memorial Hospital Calvert 5. Social Security Number Funerai 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours 2 X F Country)Maryland 1 M 214-84-8202 48 09-13-1962 Usual Residence of Deceden 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f aho or other traumatic event, the Medical Examiner must be notified at once Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 321 Sun Park Lane 20639 USA Funera 11 Marital Status 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White, etc. 2 X No 1 Yes 3 Widowed 4 Divorced If Yes, Give Yaar 1 Yes 2 X No specify: Specify: White ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Prince George's Co. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 School Bus Driver Board of Education 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Alfred Ray Martin Wanda Lee Akers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian K. Sipe, 321 Sun Park Lane, Huntingtown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) 05-28-2011 Dunkirk, MD 4 Donation 5 X Other Specify:entombment Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD w 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Small Bowel Volvulus and Infarction Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical signed by the attending physician be detached for use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy 2 Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 V Unknown pleted ficate has been si page 2 should b 24a Was an 24b. Were autopsy findings available certificate has autopsy prior to completion of cause of performed Com ✓ Yes 2 No 1 🗸 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 🗌 DOA Other Nursing Home 5 Residence 6 Other this ٩ 1 🗸 Yes 2 No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Division 5 Pending I Director: 1 Yes 2 No death. 2 Accident Investigation thin 24 hours after of 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 24, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Russell Alexander MD. 900 W. Baltimore Street, Baltimore, MD 21223 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend 5 per FD, DOR, Registrar 6/10/11, LDB Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rose Katinsky Seward 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death he Memorial eastor 8. Date of Birth Sept. 22,1918 7. Age (In vrs. last birthday) Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Months Days Hours Min. Director 92 Yrs Pennsylvania Usual Residence of Decedent , or items 23a or 28a-f shov 10a. State traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits MD Dorchester Cambridge 1 ☐ Yes 2 X No 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6016 Corners Wharf Road 21613 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: white "natural", 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ registered nurse hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Stephen Katinsky Anna Chalanics 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Mary Fogarty daughter 3113 Lake Hollywood Dr., Los Angeles, CA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Spedden Seward Cem. 6/1/11 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. lome 700 Locust St., Cambridge, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Embolism Physician/ robable Lmonar disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Aspiration neumoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Sepsis Cause (Disease or linjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical enal Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ulmonaz De8 tención 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1201 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 Tes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 ₩ No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending iniury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Moham MA D0069567 May, 24,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ravi Mohan, M.D. 219 S. Washington St., Easton, MD

State Registrar

31. Date filed (Month, Day, Year) 2011

Registrar's Signat

21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death 3. Time of Death 2 Date of Death cedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 | M 2X F Days 12/31/1950 60 401-76-1001 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 3a or 28a-f show t be notified at 10a. State 10b. County 1X Yes 2 No Director MD Charles Waldorf 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number or items 23a 6413 Fisher Ct 50203 Funeral the Medical Examiner must death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced "natural", 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Researcher / College (1-4 or 5+) Elementary/Secondary (0-12) marked other than ibrary Technician Cataloger permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked any injury or other the page. 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Edna Downs Laverne Russell ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Willie Seaberry / husband 6413 Fisher Ct., Waldorf, MD 20603 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran Cem. OL-Ol-2011 Cheltenham, MD
22. Name and Address of Facility Strickland Funeral Services 21. Signat reg Funeral Se ice Li ens 6500 Allentown Rd., Camp Springs, MD 20748 Approximate Interval Between Onset and Death mer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresshock, or heart failure. List only one cause on each line Immediate Cause (Final LEUKEMIA Syeurs ACUTE WAFFOID **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and is the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Vear Month Day in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has 2 No 1 ☐ Yes 2 ☐ No I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical 26. Place of Death Check only one Be examiner? Other: 4 \sum Nursing Home 5 \sum Residence Hospital 1 Tes 2 No 1 Inpatient 2 ER/Outpatient з □ DOA 6 Other (Specify) ၉ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? mpletely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide e Hospital 29a. Certifier (check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) To the within 2 To the I 29b. Signature and title of certifie D 30. Name and address of person who completed cause of death (Item 23a) (Ty TIMOTHY F BURNS, 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Amend #8 per FD Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AACO Health Dept. 5-26-11 KAH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:30 Month Billie Jane Schwartz Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gronde 1712/19339. Birthplace (State or Foreign ear) New York 7. Age (In yrs. last birthday) **Funeral** 24 Hrs. 8. Date of Birth Months Yrs. Director 78 28a-f shov "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Marvland Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2318 Hickory Road 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced Completed Year or Dates the Marical 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h
Dey artment of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Maria once. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Nursing Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Louis Elson Lily Fass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Schneider - Daughter 2318 Hickory Road, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Baltimore Crematory 5/27/2011 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home Muze 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of; sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a co sequence of attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death detached 1 Yes 2 Unknown the Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Griknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an autopsy performed? Yes 2 No certificate within 24 hours after death.

To the Funeral Director. After this certifical completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 PNo Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA ursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, D53111 ins Name and address of person who completed cause of death (Item 23a) (Type, Print) PAVIS MD APOLIS UND 2140 2007 TIDEWATEN COLONII 31. Date filed (Month, Day, Year) 32. Redistrar's Signature MAY 26 2011 Registrar

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Physician Medical Examine	JANET	LEE SCA	RBOROU						Month June 5, 2	Day 2011	Year	3. Time of Death 1448 hrs
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Funeral Director	5. Social Security N 219-78-	2215		7. Age (In yrs. I			ear If Und	- NA:-		irth(MM/DD/Y	Teore	
	Usual Residence of		M 2X F	52	Yrs				05/2	7/1959	C	ountMD
м апу		10b. County	13	10c. City,	, Town or Locat							10d. Inside City Limits
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and 2 sho fealth and tem 27 is traumati	20a. Method of Disp		orougn			ition (Name of co			ate			ZIID4 Town, State
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Baltimore, permit. Pages 1 a Department of He Important: If ite	21. Signature of Fur				22. N	ame and Addres	ss of Facility	y		<u> </u>		
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Physician /Medical	failure. List onl	y The cause on ea	ach line. Com	ibined d	lrug(Ser	rtraline	Diaz	epam,	Oxyco	done, ar	neant 1d	Approximate Interval Between Onset and Death
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D. B. trithe de by the ached f			9 Unknow	death but not re	sulting in the u	nderlying cause	given in Pa	ort I.	23e. Did to	obacco use cor	ntribute to	the cause of death?
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physici upletely filled in by the funeral director, page 2 should be detached for use as the burilical Certification: To Be Completed by Physician/Medi	3 Suicide	6 Could not determined	be 28e. Place	of Injury - At ho Resid		, factory, office I	building, etc		or Town, S	tate) 1529	ber or Ru Whit	ral Route Number, City
Divi Hospital or .24 hours after Funeral Dir tely filled in a	4 Homicide  29a. Certifier 1 (Check only	Certifying Physici	10,00097			ed at the time d	ate and pia		reet,	Md.		
To the Howithin 24 Prote Funcompletely	one) 2	Medical Examiner	:Dn the basis of and manner sta	examination an	id/or investigation	on, in my opinior	n, death occ	curred at the	time, date	and place, and	due to the	e cause(s)
×	29b. Signature and ti	itle of certifier	^			29c. Licens						nth, Day, Year)
	30. Name and address	Subber ss of person who	completed cause	of death (Itom 1	23.9)	0.C.	IVI.⊏.			June 6, 2	U11	
	Laron Locke		ant Medical			timore Stree	et, Baltim	ore, MD	21223			
State	31. Date filed (Month			istrar's Signatur						<del></del>		

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ Virginia L. Thorne Year 2011 12:35P.M1 MAY 30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Reeders Memorial Home Boonsboro Washington 5. Social Security Number 9. Birthplace (State or Foreign) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Min. Months 6 /3 / 19 17 236-28-5401 93 Charles Town Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Washington Boonsboro XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 141 South Main St. 21713 USA . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian VIRGINEA Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No altimore, Maryland 21215-0036 white 1 Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal If Yes, Give 3 X idowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker domestic 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Mason Mahoney Laura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Presgraves PO Box 447 Keedysville, MD 21756 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rosedale Cemetery: 6/3/2011 Martinsburg, WV Signature of Funeral Service 22. Name and Address of Facility Rosedale Funeral Home 917 Cemetery Rd. Martinsburg, WV 25404 or complications that caused the 23a. Part 1. Enter the sease Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami that the death certificate be executed and -tran that initiated events Due to (or as a consequence of): resulting in death) Last bunialattending physician for use as the buria Physician/Medical P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2 🗌 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 1 Yes 2 No or Attending Physician: director. 25. Was case referred to recipal Be 26. Place of Death heck only one) examiner? 20 9 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this completed filled in by the funeral 27. Mann Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of After 1 28c. Injury at 28d. Describe how injury occurred u atural 5 Pending injury death. 1 Yes 2 No Accident Investigation 6 Could not be within 24 hours after deal To the Funeral Director: Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the } 29b. Signature and title of certif 151 Clan CVSONS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT BRULL WYAND DRIVE KEEDYSVILLE, MARYLAND 21756 301-432-2222 31. Date filed (Mo State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 24, 2011 6:30 р м Manmohan Kaur Talwar Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Center 4b. City, Town, or Location of Death 4c. County of Death Citizens Care and Rehabilitation Frederick Frederick Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2**X** F Months Days Hours 212-11-7973 85 March Director Pakastan 1926 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1900 Rosemont Avenue 21702 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Asian If Yes, Give Year or Dates Yes 2 No Specify: Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Prithipal Singh Suri Parvati D Suri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Narinderjitsingh Talwar 1033 Dulaney Mill Drive, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot 1 ☐ Burial 2 😿 Cremation 3 ☐ Removal from State Stauffer Crematory 5-26-2011 4 Donation 5 Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licensee Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician. drawyo disease or condition Medical resulting in death) to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed bunial-tran and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months Month Year Pregnant at time of death Day 2 No ed by the a detached f g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown has been sign e 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page ( performed I Director; After this certificate It d in by the funeral director, page 1 🗌 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital ဂ္ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shal

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bonita Harrison Valien ^{Day}2011 Month 18, May 11:00pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Silver Spring 4c. County of Death Spring Prince Georges Renaissance Gardens Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign  $\begin{array}{ccc}
\text{nth, Day,} \\
\mathbf{y} & \mathbf{2}_{\bullet}
\end{array}$ 1 M 2 X 99 Yrs Days 414-50-1679 Director 1912 Texas May Usual Residence of Decedent 10c. City, Town or Location Silver shov 10a, State 10b. County within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Prince Georges Spring M D 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3160 Gracefield Road 20904 United States er than "natural", or items the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ģ 2 🔀 No Yes Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Specify: Negro 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry should be filed within 72 l and Mental Hygiene. 7 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ပ Taylor Harrison Carrie **Vickers** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Harrison / nephew P.O.Box 411824, Kansas City, MO Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 5/25/2011 Beltsville, Maryland 4 Donation 5 Other (Specify) 21. Signatu o Funeral & rvice License Funeral Service, Inc. McGuire 22. Name and Address of Facility 7400 Georgia Avenue, NW, Washington DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Dementia 5yrs Medical Due to (or as a consequence of): **Examiner** unk. Hyperlipide mia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 2 XNo detached 9 Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Completed Hyperparathyroidism 1 🗆 Yes 2 🗷 No 3 🗆 Probably 4 🗀 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy s after death. I Director: After this certificate performed 2 🔀 N 1 🗌 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1XXNatural injury 5 Pending 2 🗀 No the 1 Accident Investigation Suicide 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital of within 24 hours a To the Funeral D Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3160 Gracefield Road, Silver Spring, MD 20904 Eileen Gemmell, RNP; 31. Date filed (Month, Day, Year) Registrar's Signat State MAY 24 2011 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Medic Examin		4a. Facility Name (if not			"		4b. City, To	own, or L	ocation o		ilay		c. County of Dea		
تمويدا	)		17605 Basa	ılt Way				Hage	rsto	wn			W	ashingt	on	
	Funeral Director		5. Social Security Numl 466-68-086		м 2 🗓 F	Age (In yrs. la	ast birthday) Yrs.	If Under 1 Months		If Under : Hours		8. Date of Bird July 24		943 Wi	rthplace (State or ountry) SCOnsin	Foreign
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	TN-6		30. Name and address  Cynthia K	withner-Sc	rudz'wo.	HOSPI	CEOF	Λ (77, 1, 1,	J	Has	gers	town.	Ma	ryland	21742	
	Stat Registra	te ar	31. Date filed (Month, L	UN 0 2 20			ture									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ May 21 Gloria Litvinsky Whitman 8:20рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Nursing & Rehab Center Sandy Spring Montgomery 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Country Maryland Days YO#15"/1938 216-34-6948 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director 28a-f Bethesda 1 Yes 2 No Maruland Montgomery 10e, Street and Number ŏ 10g. Citizen of What Country? Funeral 7501 Democracy Blvd., #414 U.S.A. 20817 mit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Baltimore, Maryland 21215-0036

Permit. Page 1 and 2 should be filed within 72 hours after desperiment of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine once. Black, White, etc. 1 Never Married 2 Married \$ 1 Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Public Policy Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Leonard Litvinsky Lillian Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Whitman Chacon - Daughter 200 Market Street, Brookeville, Maryland 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Garden of Remembrance 05/23/2011 4 Donation 5 Other (Specify) Clarksburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 12-32 | 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRONCHO ALVEOLAR Physician/ CARGINOMA disease or condition resulting in death) YEAR Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of signed by the attending physician and I be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) Be Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Day 2 No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SUPRA NUCLEAR PALSY Division of Vital Records, Io the Trospine.
within 24 hourse death.
To the Funeral Director: After this certificate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) ٩ 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛭 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) Howe D33700 YAM 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Howe

MAY 24 2011

31. Date filed (Month, Day, Year)

W. Thansport

21795

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wille Donna Renee Wood Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington County Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Aug • 2 I 9. Birthplace (State or Foreign Year] 966 1 □ M 2 Ϊ Min. Months 218-06-9515 Director 44 Tennessee Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits Maryland Washington County Hagerstown 1 Tes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 315 Emmert Rd. 21740 U.S.A. items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No or, Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", 3 Divorced 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Gas Station Cashier Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Travis Mullins Dorothy Mae Mullins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William R. Wood, Jr.-husband 37 Topaz Lane Evington, VA 24550 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Gosnen Valley 6-2-2011 4 ☐ Donation 5 ☐ Other (Specify) Churchill, TN Cemetery 21. Signature of Funeral Service Licens Douglas A. Fiery Funeral Home 22. Name and Address of Facility 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Myocard Ph_sician/ Onset and Death robable disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ia 50 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last per tension Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 month 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown tens; on 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has leted filled in by the funeral director, page 2 s performed 2 🗌 No 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Certificate: To 1 ☐ Yes 2 🗙 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 Pending iniury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 000 696 06 31 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Koduan Antietam St. # 306 Hagerstown

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State Registrar 31. Date filed (Month

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month klilliam 7:45 AM Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mary tome erans narlotte If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 ☐M 2 ☐ F Min. Country) Months Hours 21 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Hughesville 1 Tes 2 No Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral MILL 7560 Acrico 20637 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Armed Forces?
1 X Yes 2 ☐ No 1951 Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 Divorced 1953 Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Worker 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မ Grant Jenevieve 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CArrico Rd Mill Aletha Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗖 Burial 2 🗌 Cremation 3 🗌 Removal from State Maryla MO 4 ☐ Donation 5 ☐ Other (Specify) Veterons 6-7-11 21. Signature of Fyneral Service Licenses 22. Name and Address of Facility 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ariest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ALZHEIMER'S DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): and Il-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the period of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the signal of the si 23e. Did tobacco use contribute to the cause of death? Completed by Records, HYPERTENSION 2 🕜 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 this certificate 1 🗌 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: 2 No Other: 1 Tes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner Death 28b. Time of Certificate: 28a. Date of injury 28d. Describe how injury occurred After (Month, Day, Year) injury 1 Natural 5 Pending nours after death. neral Director: Aff I filled in by the fur 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 1 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) D0067788 220 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charlotte HAll Road charlotte Harl, md RB3 29449 KODALI 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Allan Paul Ashbaugh :20pm <u>June</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Carroll Westminster 8. Date of Birth (Month, Day, Yea Sept 25 1 9. Birthplace (State or Foreign Country) PA Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 XM 2 □ F Hours 178-32-5885 72 **Director** Sept Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified MD Carrol1 Sykesville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7519 Dogwood Road 21784 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 195
If Yes, Give "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 No 1958-Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: white 3 ☐ Widowed 4 ☐ Divorced 1961 Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) electronics electronics technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Blaine Ashbaugh Helen Virginia McIntyre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph Godino (executor) 220 Golf Ln., Hershey, PA 17033 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State All County Cremation; 6-14-11 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityHaight Funeral Home & Chapel +thoughought P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 2 tc Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 🗌 No 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy page death? 1 ☐ Yes 2 ☑ No Yes nin 24 hours after death.

the Funeral Director: After this certific inpleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 Na-မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Doveto 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural injury 1 🗌 Yes Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State, within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 20 pleted cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day ANTHONY LOUIS 2011 ALLEN, SR. JÜNE 13 2:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death **BALTIMORE** 6803 FAIRDEL AVENUE PARKVILLE Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours Min 1 1-1-1936 216-32-4167 74 Director MARYLAND Usual Residence of Decedent or 28a-f show notified at 10a, State 10c. City, Town or Location the Maryland Director 10d. Inside City Limits BALTIMORE PARKVILLE 1 Yes 2 No MD 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o with 1 Funeral 6803 FAIRDEL AVENUE 21234 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Date KOREA 1 Yes No Specify: WHITE 3 Widowed 4 X Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DRIVER BETHLEHAM STEEL Be . Father's Name (First, Middle, Last) WILLIAM G. 18 Mother's Name (First, Middle, Maiden Surname) LOUISE MUNDLE ALLEN ပ္ 19a. Informant's Name/Relationship (Type, Print)
KIMBERLY ELLIS/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 712 WHEELER SCHOOL RD WHITEFORD, MD 21160 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 6-14-2011 CATONSVILLE, MD METRO CREMATORY 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ach line. arcinoma Immediate Cause (Final Ph_sician/ 0 disease or condition Medical resulting in death) Due to (or as a consequente of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) all or Attending Physician: The law requires that the death certificate be executed sitter death.

Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe 27 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 ANO 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death . Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred **≯** Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined o the Hospital crithin 24 hours a 24 hours Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and tile of certifie 29d. Date signed (Month, Day, Year) () 30. Name and address of person who completed cause of death (Item 23a) (Type MD 21157 Road Westminster MATHMOUD) y, Year) 15 2011 31. Date filed (Mo

DHMH 17 Rev 7/2009

State

Registrar

JUN

11-04369	
Mark Lee Baker	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mark Lee Baker		1- For State Registrar	ate of Maryla		artment of		Mental H		Reg. No. 2 (		18912
Physici		Decedent's Name (First, Midd	le,Last)					2. Date of Dea	ath		3. Time of Death
Medical Exami	ner	Mark Lee	Baker					June 10,		ear	1300 hrs
1		4a. Facility Name (if not institution	1.5	mber)	4	b. City, Town, or L	ocation of Death	1	4c. County	of Death	1
		20 East Poultney Stre				Baltimore					
Funeral		5. Social Security Number 570-02-2849		7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min	_	irth(MM/DD/YYY	Y) 9. Bir Foreig	thplace (State or
Director		J70-02-2049	1 M 2 F	54	Yrs.	I World S Days	I Tours	Nov 2	22, 1956		untry) CA
<b>≱</b> r		Usual Residence of Decedent  10a. State 10b. County		Ino Cit	y, Town or Locati						404 1 - 14 - 01 - 1 - 11 -
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ath w	Funeral	1 Never Married 2 M	arried Armed Fo	rces?		Decedent of Hispa s, specify Cuban, I				e - Ameri te, etc.	ican Indian, Black,
ter de	린	3 Widowed 4 X Div	1 Yes	2 X No	1	Yes 2 X No	specify:		Specify:	LIL	ite
urs af tural	d by	15. Decedent's Education (Spe	or Dates:			s Usual Occupatio		work done	16b. Kind of B		
72 ho	ete	Elementary/Secondary (0-12)			during mo	st of working life. D	OO NOT use ret	ired)	2.00		
036 ithin ne.	Completed		6		Н	istorian			Army C	orp	of Engineers
5-0 led w Hygic	ပိ	17. Father's Name (First, Middle				18	3.Mother's Name	(First, Middle,	Maiden Surnam		
121 i be fi ental arked veut,	Be	Robert Bak							l Kammer		
and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.  ten 27 is marked other than "natural", or items 23a or 28a-f shour tranmatic event, the Medical Examiner must be notified at once.	ျ	19a. Informant's Name/Relations				Address (Street a					
md 2 salth a		Mr. Nate Baker  20a Method of Disposition	(Son)	Lanh	Diago of Diagosi	Camarack	Circle,	Elders	burg, M	D 21	784
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 X Cremation	3 Removal fro	m State	crematory or oth	er place)	-		1	•	
im Pag ment tant:	- 1	4 Donation 5 Other S	pecify:	A1		_Cremati		2/2011	Sykesv	ille	, MD
Sall ermit Depart mpor		21. Signature of Funeral Service	1-11	-111		ame and Address o	Π	AIGHT F	UNERAL	HOME	& CHAPEL,P
	-	23a. Part I. Enter the disease, or	aught M.	00 167	Po not optouth	) Box 195	Sykesy	ille, M	ID 21784		
Physician // // // // // // // // // // // // //		failure. List only one cause	on each line.					r respiratory arr	est, snock, or ne	ап	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Hypertensiv			vascular Dise	ase				Death
		Sequentially list conditions,	b.	consequence c	J1 j.						
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	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence r	nf)·					-	
ransit and dill	Ĭ	events resulting in deathy Last	d.								
ox 68760, authoriticate be executed attending physician and for use as the burial - transit	dical	UNPENDED	AMENDED								
760, cate b	ğ	IF FEMALE:	23c. If yes, o	utcome of preg	gnancy				23d. Date o	f delivery	
68760 certificate t nding physi	an/	23b. Was decedent pregnant in the past 12 months?	I I Trive Di		46	il death 3	Ectopic pregna	incy	Month	D	ay Year
Box e death c the atten	Physician/Me	1 Yes 2 No 9 Uni		int at time of de wn	5 Oth	er (Specify)		**			
		Part II. Other significant condit		Statement	esulting in the ur	derlying cause give	en in Part I.	23e. Did to	obacco use contr	ribute to t	the cause of death?
i, P.O.	ğ							1 Yes	s 2 🗸 No 3	Prob	ably 4 Unknown
ords, I	Completed	-						24a. Was			topsy findings available
e law e has ge 2 sl	副								med?	prior to co death?	ompletion of cause of
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b		25. Was case referred to medical				26 Place of	Death (Check		2 <b>✓</b> No 1	Ye	s 2 No
Vital F ysician: his certifi director,	B B	examiner? 1 ✓ Yes 2 No	Hospital:	patient 2	ER/Outpatient		her Nursin		Residence 6	✓ Other	Scene
n of Viding Physi	-1	27. Manner of Death	28a. Date o	of Injury Day,Year)	28b. Time of In				now injury occur		
lon tendii eath. or: A	<u>آڇ</u>	1 Natural 5 Pend 2 Accident Inves	ling	Day, I ear)		1 Yes	3 2 No				
Division tal or Attendi rs after death. al Director: A led in by the fu	<u>≅</u>		stigation 28e. Place	of Injury - At h	ome, farm, street	factory, office buil	ding, etc.			er or Rur	al Route Number, City
pital Ours a curs a filled	Certification:	4 Homicide	mined (Specify)				- 1	or Town, S	itate)		
Division To the Hospital or Attenti within 24 hours after death. To the Funeral Director: completely filled in by the file		29a. Certifier 1 Certifying Pi	ysician: To the best	of my knowled	ge, death occurre	ed at the time, date	and place, and	due to the caus	e(s) and manne	r as state	d.
To th withir To th	Medical		niner:On the basis of and manner sta	examination a sted.	and/or investigation			t the time, date			
10	<b>≥</b>	29b. Signature and title of certifie	(			29c. License n			29d. Date sign		th, Day, Year)
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OGME	ſ	30. Name and address of person			,	N/ Daltimass C	Stroot Dallin	age ND 04	222		
	1/2	Mary G. Ripple MD.  31. Date filed (Month, Day, Year)	Deputy Chief M	istrar's Signatu		V. Baltimore S	oneer, Bailin	Iore, MD 21	223		
St: Regist	_	JUN 1 5 2011	A. 32. Reg	A Signall							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bay 201 Far Physician/ JYME. 8:17P BUSHROD LUELLEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY . Age (In yrs. last birthday) 8. Date of Birth **Funeral** VERGINIA 1 M 2 □ F Months Hours Min J'A97th, Day, Y92931 80 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland must be notified at Director 1 X Yes 2 ☐ No HYATTSVILLE PRINCE GEORGE'S MD 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ō USA Funeral items 23a 20785 1517 COLUMBIA AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. ral", or iter Armed Forces? 1 Armed Forces? 1 No ARMY If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married 9 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ₩ No Specify: BLACK "natural" Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturaly injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 9TH College (1-4 or 5+ PRIVATE MANAGER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, မ BROWN GRACIE HARRY BUSHROD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 COLUMBIA AVENUE HYATTSVILLE, MARYLAND 20785 BERTHA BUSHROD/WIFE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from 6/16/2011 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) VETERANS CEMETERY 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. mature of Funera 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician disease or condition Medical resulting in death) s a consequence of): Due to (or Examiner Sequentially list conditions, Examine Due to for as a noneignimor offi If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No page 2 should be detached for Month 5 Pregnant at time of death the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 100 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopo performe death? 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No Yes 1 Inpatient 2 R/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, ᅆ 27. Menner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury atural 5 Pending Accident Investigation Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. le of certifier 29b. Signature and 29c. License number 2011 D63688 leted cause of death (Item 30. Name and address of person 3001 CHEVELLY

State Registrar

GRHFIN DAVIS

**JUN 15** 

Date filed (Month, Day,

DHMH 17 Rev 7/2009

DLIVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2001 1133 Medical 4a. Facility Name (if not institution, give street and number, Examiner Town, or Location of Death County of Death SAR Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** West Virginia 1 M 2 X F Months Davs Hours Min (Month, Day, Year) 08/10/1917 93 Director 233-40-9373 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Baltimore MD Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7920 Scotts Level Road 21208 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ģ 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify. 3 Divorced 4 Divorced Specify: Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Certified Nursing Assistant Public Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown ပ Charles Washington Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1725 South FM 1417, Apt. 17101, Sherman, TX 75092 Alma Bazemore / Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Speci Anatomy Gifts Registry 06/13/2011 Hanover, Maryland Signature of Edneral Service Lice 22. Name and Address of Facility once. Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the lease, or correlications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CONGESTIVE HEART 4 MONTHS Sequentially list conditions, if any, leading to immediate cause. Enter encerning Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ျာ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Improsorres Suith Area filed (Month, Day, 15 201 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Physician/ Month June Evelyn Rosalia Bulkley 1 Day 20**1**1 10:31 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 6627 Laurel Drive Birthplace (State or Foreign Country)
 CA 7. Age (In yrs. last birthday) Yrs. 8. Date of Birth Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Min. 257-46-1848 1 □ M 2 🏋 F GA Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 ☐ No Baltimore n/a 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Completed by Funeral with USA 21207 6627 Laurel Drive permit. Page 1 and 2 should be filed within 72 hours after death to Department of Health and Mental Hygiene. I programs if item 27 is marked other than "natural", or items any injury or other traumatic event. The Medical 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Hennie Moore Leroy Burns Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6627 Laurel Drive, Baltimore, MD 21207 Melvin P. Bulkley/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Veterans : 6-20-2011 Owings Mills,MD 22. Name and Address of Facility Lie Funeral Home P.A. of Baltimore Co. Sign three Euner 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a conse Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) بر∠ Yes ر∟ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 27. Man of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Priv MD 7/17 6 31. Date filed (Month, Day, Year) Registrar's Sig State 5 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month 14:20 PM **Physician** June Michael Brewington 96 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and numb Examiner Johns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept | 22 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 2 🗆 F 1967 mD 43 218-98-4021 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Int. If item 27 is marked other than "natural", or Items 23a or 28a-f show iny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes ¾☐ No Director Middle River Baltimore MD 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip-Code 21220 U.S.A. Funeral 39 Oak Grove Road Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) DTM Security Co. Security 2 vrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ann Berry Lloyd Brewington, Jr. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Spotsylvania, VA 22551 5706 E. Point Circle Sharon Brewington - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages
Department of
Important: If it
any Injury or o Crownsville, MD 6/15/2011 Crownsville VA Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 4300 Wabash Ave.
March Funeral Home West, Inc. Balto., MD 21215 21. Signature of Funeral Service Licensee 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory fa Due to or as a conservence of) failure **Physician** 12 hours /Medical Examiner 2 weeks Cerebral edemo Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury weeks nding physician and use as the burial-transit Astrocytomo The law requires that the death certificate be executed Recurrent anaplastic that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 □ No 1 ☐ Yes 1 TYes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 🗌 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident death. Director: 6 Could not be determined 3 Suicide 28f. Location, (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by City or Town, State) 4 Homicide after 1 Pcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

within 24 hours a

State Registrar

Sharrief Anjai 1 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(check only one)

M. A 32. Registrar's Signature arks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

AES-000

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

June 06, 2011

			For State Registrar  1. Decedent's Name	e (First. Middle, La	State of M	arylan 		artment tificate				ental Hy  2. Date of De	Reg. N	201	3. Time	3917
9	Physicia Medio		HELEN		A.		BOE	SCHE						2011 Year		0 <b>A</b> M
ي	Examir	er			e street and number)  RE CENIER			4b. City, T		Location RKVI			40	c. County of De <b>BAI</b>	ath TIMOR	E
Ź	Funeral Director		5. Social Security No. 218-14- Usual Residence of	-8127	Sex 7. Ag 1 □ M 2 🔀 F		88 Yrs.	If Under 1 Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da 6 – 26 –	th Year) 192	2 MA	irthplace (State Country) ARYLANI	
A	Maryland :8a-f show xified at	Director	10a. State MD	10b. County	LTIMORE	10c. City	, Town or Lo	cation	PZ	ARKV	ILLE				10d. Inside	City Limits
0430	with the 23a or 2	Funeral Di	10e. Street and Num 8810 W.Z		BLVD			10f. Zip (		234			10g. C	itizen of What 0	-	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status  1 🔀 Never Marri 3 🗌 Widowed		12. Was Decedent B Armed Forces? 1 Yes 2 A If Yes, Give Year or Dates.	Ever in U.S	Į:	Vas Decede Yes, specif	y Cubai	n, Mexica	n, Puerto Ri	fy Yes or No- can, etc.)		14. Race - Am Black, Wh Specify: W		
E L E N 21215-0036	ithin 72 hou iene. r than "natu the Medical	Completed	(Spec			ō+)	(Give I	O NOT use r	done d	uring mos	st of working		[ ]	Kind of Busines		IMORE
工 pue	d be filed w Mental Hygi arked othe atic event, 1	To Be	17. Father's Name (F HENRY			ESCHI	€	_			ner's Name (i	First, Middle,			UNKNOV	
O Mary	id 2 shoul salth and I n 27 is m er trauma		19a. Informant's Na	. ,	Type, Print) SEY/NIECE	E		g Address ( MELI				Route Numbe		r Town, State, 2 G , MD	Zip Code) 2178	3 4
eSC ∤	Page 1 an iment of He tant: If iten jury or oth				Removal from State	Ce	ace of Dispo emetery, cren STERN	natory or oth	ner place		Da 6 – 18 -			ocation - City o		
Goes ■ Baltin	permit Depart Impor any in		21. Signature of Fun	eral Service Licen	see			Name and				CH/ROS ROSI		ALE FU LE, MD		
G	Pnysician/ Medical	8 15	23a. Part 1. Enter the shock, or hear Immediate Cause (Find disease or condition resulting in death)	t failure. List only o Final	nplications that caused one cause on each line a.  Due to (or as a	ioca	reine		2.5			respiratory ar neta		ette	Approxima Interval Be Onset and	etween
	Examiner	Jer	Sequentially list cor if any leading to in cause. Enter Under	nditions,	b.										-	
	executed an and ial-transit	Examiner	cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	injury	c. Due to (or as a											
3760	ficate be exe g physician as the burial	Medical			d								_		1	
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death, within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi		IF FEMALE: 23b. Was decedent   in the past 12 m 1 ☐ Yes 25 9 ☐ Unknown	nonths?	23c. If yes, outcome  1  Live Birth 4  Pregnant a 9  Unknown	2 🗌 Fetal	death 3	Ectopic pro Other (spec	egnancy cify)	У				23d. Date of d Month	elivery Day	Year
ds, P.O.	quires that t en signed b uld be deta	ğ		SCVD	contributing to death b	ut not resu	Ilting in the u	nderlying ca	use give	en in Part	1.			use contribute		
Division of Vital Records,	<b>hysician:</b> The law rec his certificate has bee I director, page 2 sho	Completed									_	24a. Was autor perfo	osy rmed?	prior to death?	utopsy findings completion of es 2 No	
ital	ician: certific rector,	Be	25. Was case referre examiner?		Hospital:				TOthe		th (Check o	100				
of V	g Phys er this eral dii	e: 10	1  Yes 2 2 27. Manner of Death	K _{NO}	28a. Date of injur	rv I	R/Outpatien 28b. Time of		c. Injury	at 4 LVN		e 5 🗌 Resid d. Describe h		6 Other (Sperry occurred	ecify)	
ion	eath. or: Afte the fun	Certificate:	1  Natural 2  Accident 3  Suicide	5 Pending Investigatio 6 Could not be		(, Year)	injury	М	work?	Yes 2	No No					
Divisi	To the-Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completed filled in by the funeral di		4  Homicide	determined	building, etc	. (Specify)						City or Tow	n, State			aber,
00	nd-Hosp n 24 ho ne Fune pleted f	Medical	(Check 2		rsician: To the best of liner: On the basis of ex se Practioner: To the	xamination	and/or investi	gation, in my	y opinior	n, death o	ccurred at th	e time, date a	nd place	e, and due to the	e cause(s) and m	anner stated.
V.	To the with To the comment		29b. Signature and to	itle of certifier	Brazier	_ (1	ENP			number RO	6734			ate signed (Mon		>11
	0		30. Name and address Alice M		completed cause of de	eath (Item	23a) (Type, Pi	rint)	1./-1	D	OPK	110	IN	ine 1	24	
	Stat Registra	-	31. Date filed (Month		32. Egistra	⊭'s Signatu	1. 1	all I	VC		/7/1\13V	1112	VID	1112	2	

11-04427	
Tara Brooks	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ara brooks		1-For State Certificate			2011	1891
Physicia	an/	1. Decedent's Name (First Middle Last)	<u> </u>	Reg.  2. Date of Death		3. Time of Death
Medical Exami		Tara N. Brooks		June 12, 201		1504 hrs
£		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death Baltimore	h	4c. County of Death	
Funoral		University Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	s. 8. Date of Birth(	MM/DD/YYYY) 9. Birth	pplace (State or
Funeral Director		216-86-8367 10M 2VF 41	Months Days Hours Mir	_ `	Foreign	
ADA		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	cation			10d. Inside City Limits
and show	ō	MD Baltimore Caton	sville			1 Yes 2 100
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Count	ry?
with the Maryland ns 23a or 28a-f sho be notified at once	Ö	176 Winters Lane	21218		USA	
ath wi	Funeral	1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? ( S f Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,
fler de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 No specify:		Specify: B	ick
lours a	ed by		lent's Usual Occupation (Give kind of most of working life. DO NOT use ret		6b. Kind of Business/In	dustry
5-0036 led within 72 hours after death with the Maryland Hygicine. I other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)   College (1-4 or 5+)   /	ustodian		Aramar.	K. Corp.
	Be Co	17. Father's Name (First, Middle, Last)  Joris Brooks		(First, Middle, Maid	den Surname)	
ID 2121 should be fil and Mental F 7 is marked natic event,		1 formant's Name/Relationship (Type, Print )	ing Address (Street and Number or	Rural Route Number	r, City or Town, State,	
■ Pd 2 alth		Iris Hebron (Grand Mother) 176 20a. Method of Disposition 20b. Place of Disp	Winters Lane, (		Oc. Location - City or T	
Baltimore, permit. Pages 1 at Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State Crematory or	other place)		Baltimor	
lit. Pa artmen ortani		4 Donation 5 Other Specify: 21. Signature of Puneral Service Linens 22	Mount 6-	15-11	00177110	L'CES
Balt permit. Departi Import	^	Vaugha C. Steere 5	151 Bacto, Na	t'i Pike	(21229	
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	r the mode of dying, such as cardiac o	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
£xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Pulmonary Hypertens  Due to (or as a consequence of):	ion AD Scleroderm	a		Death
		Sequentially list conditions,  b				
	iner	if any, leading to immediate Due to (or as a consequence of):			2	
- A.	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
n and recuted		d.  X UNPENDED AMENDED 23a,27,per me,	g016 62011 cm			***************************************
60, ate be execut hysician and le burial - tran	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	,8910 0-29-11 Sm	Т	23d. Date of delivery	
5876 rtifica ling ph	an/N	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregna		Month Da	ay Year
Box 6876  he death certificat  the attending phyed for use as the	Physician/	4 Pregnant at time of death 5	Other (Specify)			
that the d		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?
of Vital Records, P.O. og Physician: The law requires that the ther this certificate has been signed by inneral director, page 2 should be detach	d b			1 Yes	2 No 3 Proba	ably 4 🗹 Unknown
ords w requires been should	Completed			24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
Reco The law cate has	EO			performe 1 Yes 2 ▼		2 No
tal Recian: The certificate ector, page	Be	25. Was case referred to medical examiner?  Hospital: 1 ✓ Inpatient 2 ER/Outpatie	26.Place of Death (Check			
of Vit	욘	1 165 2 140	THE SECOND THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STA	ng Home 5 Res	sidence 6 Other.	
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Division al or Attendiu rs after death. al Director: A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st	reet, factory, office building, etc.	28f. Location (Stre or Town, State	et and Number or Run	al Route Number, City
Divis Hospital or At 24 hours after d Funceral Directed filled in by	Ser	4 Homicide determined (Specify)		or rown, state		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be Anthin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	ica	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occore one)  2 Medical Examiner: On the basis of examination and/or investig	curred at the time, date and place, and gation, in my opinion, death occurred a	d due to the cause(s at the time, date and	) and manner as stated I place, and due to the	d. cause(s)
To the comple	Medica	and manner stated.  29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Mon	
2		Theta MY a The 1	O.C.M.E.	^{SME} J	lune 13, 2011	
$\emptyset$	ŀ	30. Name and address of person who completed cause of death (Item 23a)				
		Theodore M. King, Jr., MD. Assistant Medical Examiner	900 W. Baltimore Street, B	Baltimore, MD 2	1223	
St Regist	ate	31. Dee Not Mach, 24 Mar) 32. Registry's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month 10:48 AM 2011 Rita M. Bush /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AGINES BALTIMORE n/a 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 💢 F 5/1/1924 Maryland Director 054-18-3313 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 273 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Mixeline Exa. Il wit must be inclined any injury or other traumatic event, it. Mixeline Exa. Il with the inclined any injury or other traumatic event, it. Mixeline Exa. Il with the inclined and injury or other traumatic event, it. Mixeline Exa. Il with the inclined and injury or other traumatic event, it. Mixeline Exa. Il with the injury or other traumatic event, it. Mixeline Exa. 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Citizen of What Country? 10e. Street and Number 1405 Claridge Avenue 21227 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Manufacturing 10 <u>Seamstress</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peter Meola Josephine Lazzara 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Regina Rent / Daughter 1405 Claridge Avenue, Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6/14/2011 Baltimore, Maryland Bayview Crematory 4 □ Ponation 5 □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. ure of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21227 Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ALVEOLAR HEMORRHADE Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 MILMONARY EMBOLISM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed DISBASE 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 877458 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Man or of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury • Hospital or Attending Pl 24 hours after death. • Funeral Director: After the 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MEDICAL PESIDENT 12 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MA 31. Data filed (Month Day Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Clyde Walker Boyd June 10, 8:00 a.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7419 Hill Court Dunda1k Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Nov . 28, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) 1<u>934</u> 1**XX**M 2 □ F Days Hours Min. **Director** 226-40**-**4438 76 Virginia Usual Residence of Decede show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 Yes 2 No Maryland Baltimore Dunda1k ō 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 7419 Hill Court 21222 United States items and 2 should be filed within 72 hours after death Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or iter 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXXNo Specify: 3 Widowed 4 Divorced Specify: Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) <u>8 years</u> Welder-Bethlehem Steel Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of r traumatic ever မှ Dewey Henry Boyd Mattie Pearl Flieschman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4801 Berryhill Circle- Apt. 301 Perry Hall, Md. 211 8 Joseph J. Boyd, Sr. (Son) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) 6/14/2011 Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licer Duda-Ruck Funeral Home of Dundalk, Inc. 2000 G Wise Avenue Dundalk Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ acute respiratory disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner rumonary disease (LOPD) hronic obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events burial-trai Due to (or as a consequence of): resulting in death) Last nding physician ause as the burial Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery atten 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No ō Month Pregnant at time of death
Unknown Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 XYes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4  $\square$  Nursing Home 5 Residence 6  $\square$  Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury To the Hospital or Attendia within 24 hours after death. To the Funeral Director: Af completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, Balanion M.D. D0055157 Jun 10,201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9600 North Point Rd. Fort BA Medical VA

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month +01 2:35 Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min NORTH CAROLINA Director 38-22-6720 Usual Residence of Decedent or 28a-f shov "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits BALTIMORE 1 Yes 2 □ No MD 10e. Street and Number 10g. Citizen of What Country? Funeral 5524 WESley U.S.A 2120 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 ☐ Divorced 1946 Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MEAT CUHERS Elementary/Seconday (0-12) College (1-4 or 5+) ABOREI Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည BROOKS 19a. Informant's Name/Relationship (Type, Print) DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PIEASANT VAILEY DR., CATONSUILE, MARYIAND YOUNGER MARGUERITA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition bate, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State OWINGS MILLS, MARYLAND 22 /2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee DERRICK C. JONES FIIH, P.A. 23a. Part 1. Enter the disease, or complications that taused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Lugartense Medical Due to (owa a consequence of) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 2 No detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 W No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate I performed 2 🗆 No 1 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1650 4538 EDMONSON AV, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Andrew Scott Bester

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

UNK UNK	1- For State Registrar		e of Maryland		ment of ficate of		na Men	ital Hyg		eg. No.	2011	18922
Physician Medical Examine		ne (First, Middle,La COTT BES						- 1	Date of Deat Month June 2, 20	Day	Year	3. Time of Death 2035 hrs
		if not institution, g rge's Hospital	ive street and number) Center		41	c. City, Town, Cheverly	or Location			4c. C	ounty of Death	
Funeral Director	5. Social Security N 043-48-9	347	Sex 7. Ag X_M 2 F	e (In yrs. last 48	birthday) Yrs.	If Under 1 Ye Months Da	ear If Unders		3. Date of Birt		Foreig	thplace (State or in untry) CT
any	Usual Residence of 10a. State	f Decedent 10b. County		10c. City, To	wn or Locatio	n				-		10d. Inside City Limits
ne Maryland or 28a-f show fied at once.	DC	N/A	4	WAS	HINGTO							1 Yes 2 No
the Maryland is or 28a-f sh tiffed at once Director						10f. Zip Code 20003				USA	n of What Cour	ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumantic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director				Ever in U.S.	If Yes	Decedent of H s, specify Cuba Yes 2 N	an, Mexican	, Puerto Rio			White, etc.	can Indian, Black, HITE
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5-0036 ivgiene, n. 72 hours afther than "natural" the Medical Examine Completed by	Elementary/Seco		College (1-4 or 5 4		=	T MANA		400 1011104		CON	NSTRUCT	ION
MD 21215-0036 11.2 should be filed within 7 th and Mental Hygiene. 1.27 is marked other than umarke event, the Medical To Be Comple	ROGER SC	OTT BEST	OR				NANC	CY ROS			·	
AD 21 2 should and Me 27 is ma matic ev	19a. Informant's Na			1		Address (Stre SUDBUR			Route Num		or Town, State	Zip Code)
ore, Nealth	20a. Method of Dis	position	Removal from Sta			on (Name of c			ate		cation - City or	Town, State
Baltimore, permit. Pages 1 ar Department of Hee important: If ite	4 Donation 5 21. Signature of Fu	Other Specifi	r.			CREMAT		6/15/			BURNI	
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Physician /Medical Examiner	23a Part)l. Enter the failure. List on Immediate Cause ( or condition resulting	Hy∕one cause on e Final disease a	plications that caused ach line. Gunshot Wound Due to (or as a conse	of Neck	not enter the	mode of dying	g, such as c	ardiac or re	spiratory arre	est, shock,	, or heart	Approximate Interval Between Onset and Death
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ted Insit	if any, leading to im cause. Enter Unde (Disease or injury to events resulting in	rlying Cause hat initiated	Due to (or as a conse									
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Vital Reorganis: The his certificate director, page	25. Was case referr examiner?		Hospital: 1 Inpatier				e of Death (		one)			
n of Vi ding Physi I. After this funeral dir	27 Manner of Dooth	2 No	28a. Date of Injur	y 28t	Outpatient :		Uther at Work	? 280	ome 5 F	ow injury o		
C = 1 2 3 5	1 Natural 2 Accident	5 Pending Investigat	ion Jun 2, 2011	19	OUND: 49 hrs		Yes 2	No	bject shot			
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	30. Name and addre	ess of person who	completed cause of de	ath (Item 23a	1)	0.0	.M.E.	_		June 4	, 2011	
5	Donna M. Vi	ncenti, MD	Assistant Medica	al Examine	er 900 W	/. Baltimore	e Street,	Baltimore	e, MD 212	223		
State Registrar	31. Date filed (Mont)	r, Day Year)	32. Registrar	s Signature	Land .							

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Stat Registra	

			Please	State of Mary				-		gible.	
			State Registrar		Cer	tificate of L	Death		Reg. No.2		18923
	Physicia Media		Decedent's Name (First, Middle, Last     RAYMOND FREDERICK					2. Date of Dea Month JUNE	Day	Year 2011	3. Time of Death 8:30 P M
	Examir	ner	4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or	Location of Death			y of Death	
in Mark	Funeral		STELLA MARIS 5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	TIMONIU If Under 1 Year	M If Under 24 Hrs.	8. Date of Birtl		IMORE	lace (State or Foreign
	Director			X M 2 □ F 77	Yrs.	Months Days	Hours Min.	(Month, Day FEB 25	(Year)	Count	
	Maryland 28a-f shoo otified at	Director	10a. State 10b. County BALTIMO	DRE 100	c. City, Town or Loc OVERLI	cation EA				1	0d. Inside City Limits 1 ☐ Yes 2 🋣 No
	s 23a or hust be no	Funeral D	10e. Street and Number 4517 FORESTVIEW A	AVE		10f. Zip Code 21206			10g. Citizen of USA	What Coun	try?
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1  Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces?  1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	lt lt	Vas Decedent of Hi f Yes, specify Cuba	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla Specify	ce - America ck, White, e V	an Indian, THITE
21215-(	/ithin 72 hou iene. r than "nat the Medica	Completed	15. Decedent's E (Specify only highest group) Elementary/Seconday (0-12)		(Give F	lent's Usual Occup kind of work done o O NOT use retired) OGRAPHER	ation during most of work	king	16b. Kind of E		
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, Man	nd 2 shoul ealth and I n 27 is ma er trauma		19a. Informant's Name/Relationship (TPATRICIA BLACKSTO	ype, Print) OCK-WIFE	19b Mailin 45 17	FÖRESTVÍ	EW AVE	BALT IMOR	E ^{ity} o'MD ^{wn,}	211206°	ode)
Baltimore, Maryland 21215-0036	permit. Page 1 and Department of Heal Important: If item any injury or other		20a. Method of Disposition  1 ★ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Licens	Removal from State fy)	GARDENS (	natory or other place OF_FAITH	6/1	Date 5/11	20c. Location  BALTIN  PET. FIII	MORE,	
B	Dep Imp any any		HOR			6415 BELA	IR RD	BALTIMOR	E, MD		Approximate
المحادث	Physician/ Medical Examiner	Examiner	shock, or heart allure bist only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	a. CHRONIC ( Due to (or as a cor  Due to (or as a cor	DBSTRUCTI nsequence of):					1,	Interval Between Onset and Death
98760	rtificate be executed ing physician and e as the burial-transit	g	resulting in death) Last  IF FEMALE:	Due to (or as a cor							
). Box 6876(	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.  On the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the I	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1  Live Birth 2   4  Pregnant at time 9  Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	У		- 1	ate of delive onth	ry Day Year
Division of Vital Records, P.O.	equires that sen signed bould be det	ਨੂ	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.				e cause of death?
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Divisio	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completed filled in by the funer	I Certificate:	3 Suicide 6 Could not b 4 Homicide determined		At home, farm, stre	eet, factory, office		28f. Location (Si City or Town		per or Rural	Route Number,
	To the Hospital within 24 hours To the Funeral completed filled	Medical	(Check 2 Medical Exami only one) 3 Certifying Nurs	sician: To the best of my k ner: On the basis of examing se Practioner: To the best	nation and/or invest	igation, in my opinio	n, death occurred a	t the time, date ar	nd place, and du	e to the cau	se(s) and manner stated
	vitil Co.		29b. Signature and title of certifier  Tunecia V	Vhite o	RNF	29c. License	274	74	29d. Date signe $6/7$	13/1	ay, Year)
04	11		30. Name and address of person who c			,	m	,	1000	7	
1	Stat	te	JUNECIA WHITE, C. 31. Date filed (Month, Day, Year)	32. Registrar's S	JLANEY VA	LLEY RD.	TIMONIU	M, MD 21	1093		
	Registra		JUN 1 5 2011 /2		ball						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 9:35 PM **Physician** 2011 June /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Fian iner ltimor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT. 25,1920 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min 1 ☐ M 2 💢 F 90 MD Director 214-12-9189 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. Count r 28a-f show notified at 1 Tyes 2 No Director N/A BALTIMORE filed within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or 3203 JUNEAU PLACE 21214 USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No WHITE Baltimore, Maryland 21215-0036 Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) DRUG STORE SALES 7 Is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f Department of Health and Mental ! WILLIAM L. PRESTON BETSY M. MCCULLIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ROSEMARY LANG-DAUGHTER 3716 HILLTOP DR JOPPA, MD 21085 27 Important: If Item 27 any Injury or other the once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☐ Pther (Specify) ATLANTIC CREMATORY 6/14/11 GLEN BURNIE, MD 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 23a Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician recus Due to (or as a consequence of) disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician ar Box 68760, Physician/Medical as attending properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the properties of the pr IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 DEctopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 2 7 No Ö 9 Unknown 9 Unknown s been signed by ti Division or Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe this certificate 2-7 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient ٩ 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Hospital or Attending 1 Matural 5 Pending investigation To the nospinal within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

6 v

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

lee

Marsha

31. Date filed (Month, Day,

Drive

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ 25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel **Brooklyn** 110 W. Hilltop Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day Months Days Hours Country) 1 M 2 □ F MD Director 59 220-56-8656 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified or once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🗱 No MD Anne Arundel Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21225 110 W. Hilltop Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 KMarried Yes 2 XXNo Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify Specify. B1ack 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Flementary/Seconday (0-12) College (1-4 or 5+) Logistics Supervisor 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lillie Jackson Elbert E. Best, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 W. Hilltop Rd., Brooklyn, MD 21225 <u>Sandra Best</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery Glen Burnie, MD June 11, 2011 4 Donation 5 Other (Specif yure of Funeral Gervice L 22. Name and Address of Facility Fink Funeral Home, P.A. Gregory Fink M01148 426 Crain Hwy S., Glen Burnie, MD 21061 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the diseas shock, or heart failure. Approximate Interval Between or nset and Death Immediate Cause (Final THORAX Ph_sician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Secure tisibuliet eandliche Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy performed death? 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medica Division of Vital 26. Place of Death (Check only one) director Be examiner? Hospital: 2 1 No မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certific 29c. License number 8 2011 10 U

State

31. Date filed (Month, Day, Year) JUN 15 2011 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature park

DEFENSEHWY, ANNAPOLIS, H.D. 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2011 10:00A M June Lawrence Andrew Carter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number VNK 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** June7,1928 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Madical Exeminar in ust be notified at 1 □Yes 2√2 No Director Silver Spring Maryland | Montgomery 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number U.S.A. 20994 2101 Fairland Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 □Yes 2 TNo Specify Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r. Elementary/Secondary (0-12) College (1-4or 5+) Salesman Advertising 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental I Important: If Item 27 Is marked any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any in Ruth Mayo Fred Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22306 19a. Informant's Name/Relationship (Type. Print) 7839 Richmond Highway, Apt. 216, Alexandria, Virginia Helen Carter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hanover, Maryland ArdentCremation,Inc. 6-8-11 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael ! margallo 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or commecations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** WK Septicemia (Gram Negative) /Medical Due to (or as a consequence of): Examiner WK Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed <u> Alzheimer's Dementia</u> and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 □Yes 2 □No signed by the a 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Parkinson's Disease, E. Coli Sepsis Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Nonstageable pressure ulcers autopsy performed? 1 ☐ Yes 2 ANo 1 ☐ Yes 2 ☑ No e Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State
 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6 Physician/ Day 20 11:00A. ™ Medical acility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 618 Linnard Street Baltimore 8. Date of Birth (Month, Day, April 2: 9. Birthplace (State or Foreign Country) DistrictofColumbia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 □ M 2X F Hours 382-05-8766 Director 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at onee. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 618 Linnard Street 21229 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edith Stearn George Gray it. Page 1 and 2 shours of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helena Walker 1350 16th Street, Orange City, Florida 32763 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State ArdentCremation, Inc. 6-14-11 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. Signature of Funeral Service Licensee 6009 Harford Road, Baltimore, Maryland 21214 nuklu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line terval Between Immediate Cause (Final h sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi Cause (Disease or iiniury that initiated events Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) n signed by the a q ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an as autopsy performed death? 24 hours after death. Funeral Director: After this certificate 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) ၉ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED LIVE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 31. Date filed (Month, Day, Year)

JUN 1 5 201 32. Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:20 AM arrivation-2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** loseph Kitchie tospice att more If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral Months Days Hours Min (Month, Day, Country) 213-16-654 1 🗆 M 2 🖫 Director June Usual Residence of Decedent per nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Desartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Nes 2 □ No moul 10f Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 2 -121 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married Yes 2 Jun 6 Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during I life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bayview Hospital Be 18. Mother's Name (First, Middle, Majden Sumame) 17. Father's Name (First, Middle, Last) ပ္ Mallor Morgan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ssie 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place Burial 2 Cremation 3 Removal from State 20/2011 rrison 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign ture of Funeral Service Licensee Hom it mou ams node of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that constitutes the shock, or heart failure. List only one cause on each Approximate sed the death. Do not enter the Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 1 Yes 2 9 Unknown within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 shruld be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗆 No 1 Tes Hospital or Attending Physician: 25. Was case referred to nedical 26. Place of Death (Check only one) Division of Vital Be examiner? Other: 2 No ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check the 29b. Signature and title of certi 29d. Date signed (Month, 2 0 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who con 0 Registrar's Signature 31. Date filed (Month, Day, Year) State 5 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10Pay 201/et James O. Clagg Jone : 30A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 13 Akin Circle Middle River Baltimore Social Security Number If Under 1 Year If Under 24 Hrs, 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Age (In vrs. last birthday) (Month, Day, Year) Aug. 16,1935 West VA Days 232-56-3355 1 □**X**M 2 □ F Hours 75 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Middle River 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13 Akin Circle 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by ☑**X**Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Crown-Cork&Seal Elementary/Seconday (0-12) Maintainer College (1-4 or 5+) 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clagg မ Laben Clagg Eva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Clagg /wife Akin Circle Baltimore MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot cometery, crematory or other place)
Holly Hill Cemetery 6/14/11 Baltimore MD 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Juneral Service Licens 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ -YMPHOMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery signed by the atte in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HEAD? 1 Yes 2 No 3 Probably 4 Unknown Completed CONCESTIVE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 Yes 2 🗖 No Yes To the Funeral Director: After this certific completed filled in by the funeral director, Ba 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 1 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Sanature 29d. Date signed (Month. Dav. Year) 4 4456 le ss of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0825PM Physician/ Charles Μ. Case June 9 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Union Memorial Hospital 1 Year If Under 24 Hrs.
Davs Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1**X**XM 2 □ F Months Oct. 3, Year 954 Baltimore. 56 213-52-4378 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1240 N. Calvert St 21202 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2XXNo Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4XXDivorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Beverage Distribution 12 Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Velma Aiello Francis Case 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21214 5915 BertramAve. Michael Case / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Towson, MD 4 Donation 5 Other (Specify) Hilltop Service Corp. 6/11/2011 Signature of Funeral Service 22. Name and Address of Facility 5305 Harford Rd. Leonard J. Ruck, Inc. Baltimore. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. -STAGE LIVER DISEASE! Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy nerforme Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: After ! work?
1 Yes 2 No 1 Natural injury 5 Pending Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Decelyne conatchou, ms D63748 June, 9th, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union memorical Hespital, Bultimore, mary land TOURLYNE KOUATCHOU

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

JUN 1 5 2011

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene									
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			Registrar  1. Decedent's Name (First, Middle, Last)	Cert	tificate of Death	2. Date of Death		3. Time of Death	
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·		1175 Sarge  5. Social Security N		S. Sex	tre Is Date of Bird	th/AAA/DD/VVVVI	Birthplace (State or)							
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ith the Maryland 123a or 28a-f show : notified at once.	Director	10e. Street and Nu		Street			10f. Zip Code	11222	10	og. Citizen of Wha	it Country?			
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Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.		29a. Certifier 1 (Check only			-				nd due to the cause					
To the within To the comple	Medical	one) 2 ✔ 29b Stgpåture and		ner: On the basis of and manner s		nd/or investigati	on, in my opinio		d at the time, date a					
	~	2.50 roigipalure and	111	11	1	-		.M.E.		May 25, 201	l (Month, Day, Year) 1			
	ŀ	30. Name and addre	ess of person w	ho completed caus	se of death (Itèm	23a)								
		Zabiullah Ali		sistant Medic			altimore Stre	eet, Baltimore	e, MD 21223					
St	ate	31. Date filed (Mont	h, Day, Year)		egistrar's Signatu	ire back								

DHMH 17 Rev 1/2001

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 20<u>11</u> Physician/ Calhoun, Sr. 12:00PM Manley Paul June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air I Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 😾 M 2 🗆 F Months Davs Hours (Month, Day, Ye Year) Maryland Director 87 217-12-7000 Aug. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A 1 XYes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 U.S.A. 5205 Barbara Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces' Black, White, etc. 1 Never Married 2 Married δ 1 XXes 2 □ No If Yes, Give Maryland 21215-0036 1 Yes 2 XXNo Specify: 3 X Widowed 4 ☐ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Union 10 th. Grade Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Belle Edward Calhoun, Sr. Manlev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 Ponfield Road W. Forest Hill Kevin Calhoun/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 06/13/2011 Glen Burnie Atlantic Crematory 21. Signatur of Funeral Service Licen e 22. Name and Address of Facility
Miller-Dippel Funeral Home, Inc.
6415 Belair Road Baltimore MD 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure last only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) 21206 Onset and Death Physician/ Medical Due to (or a /a consequence of): Metabolie Aciclosis Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending physi IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 | Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) been signed by the should be detached Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 performed? Hospital or Attending Physician; The certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ည 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completed filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20056607 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLUMTREE Rd. Suite D. BEL AFR, MD 201 ANGEZO 208 32. Regist ar's Signature State Registrar

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/aiter Coleman		State of Maryland / Department of He  - For State Certificate of De			201	1893
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3alt ermit. Separt mpor		21 Scinatory of Funeral Service Licensee 22-Name	ephore of Facility own N. Fulton	n Jr. Fu	ineral Ho	ome PA
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Physician /Medical		failure. List only one cause on each line.				Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Attlefoscierotic Cardiovascular Disease or condition resulting in death)  Due to (or as a consequence of):	5			
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To To Com	Med	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (M	onth, Day, Year)
•			O.C.M.E.		June 7, 2011	
•		30. Name and address of person who completed cause of death (Item 23a)		1		
		Donna M. Vincenti, MD Assistant Medical Examiner 900 W.	Baltimore Street, Balti	imore, MD 212	23	
	tate					
Regi	strar				<del></del>	
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 3011 icia /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Sept. 15, 1942 5. Social Security Number Age (In vrs. last birthday Days **Funeral** N.C 212-42-1687 68 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 28a-f show 1 ☐ Yes 2 ☐ No notified at Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō ral", or items 23a of 21213 1332 N. Luzerne Ave. USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 X Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Specify: Black þ 3 Widowed 4 Divorced "natural" 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) other than vent, the Mer Elementary/Secondary (0-12) College (1-4 or 5+) M. Kovens Bookkeeper 12th 18. Mother's Name (First, Middle, Maiden Surname) event, t 17. Father's Name (First, Middle, Last) Be Mental Rosalee Stevenson 27 Is marked of traumatic ever George Cauthen ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 Is
any injury or other trau MauKeith Cauthen (son) 1332 N. Kuzerne Ave. Balto, Md. 21213 June 14, 2011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State GreenMount Crematory 4 Donation 5 Other (Specify) Balto, Md. calvin B. Scruggs Funeral Home 21. Signature of Funeral Service Licenses 1412 Ε. Preston S. Balto, Md. Approximate Interval Between the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ongestive **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner oronal if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performe 2 🗌 No 2) 1 TYes certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes မ Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deat 28b. Time of Certification: After 1 Natural 2 Accident 5 Pending investigation Injury s after deau... 1 ☐ Yes 2 ☐ No M Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, filled in by City or Town, State) 4 THomicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Hospital 29a. Certifier (check only Medical one) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. B

Shanahan

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Physician/ 0 2011 June Mary Jean Dowell Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (if not institution, give street and number) **Examiner** Baltimore n f If Under 24 Hrs. Min. Futurecare North Point 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Dec. 23 7. Age (In yrs. last birthday) Country)
Maryland Min **Funeral** Months Days Hours 1 □ M 2**X**XF Yrs Director 217-24-9330 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 Yes 2 No must be notified Dunda1k **Baltimore** Maryland 10g. Citizen of What Country? 10f. Zip Code ō 10e. Street and Number "natural", or items 23a edical Examiner must be United States Funeral 21222 7472 Rabon Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 2 Married þ 1 Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 White 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 12 years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any Injury or attendant Edna P. Fanwell မ Louis S. Orem 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>Maryland 21214</u> Baltimore, 2908 Sylvan Avenue <u>Bonnie L. Maher</u> (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Rossville, Maryland 6/14/2011 of 4 ☐ Donation 5 ☐ Other (Specify) Faith Cem. 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licenses ▶ 7922 Wise Avenue Dundalk, Maryland art 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure and tonly one cause on each line. Approximate Approximate Interval Between Onset and Death (an (0 1 Immediate Cause (Final disease or condition resulting in death) -Physician/ Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or liniury and that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No cate has been signed by the a page 2 should be detached 1 ☐ Yes ∠ u 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 2 1 No 1 Yes 21 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes မ 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death s after death. I Director: After t Certificate: iniury work 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident within 24 hours after death

To the Funeral Director: /
completed filled in by the f 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Hospital Medical 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-38754 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709. EASTERND BLVD. ASERM

DHMH 17 Rev 7/2009

State Registrar MAUKA (
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2011 Month 2115 М Physician/ June 8, Carroll Dabkowski Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Paltimore Rosedale Manor Care - Rossville 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Maryland Days Hours 1 XM 2 F Months 1170274941 69 220-38-9171 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10a, State 10b. County Director 1 1 Yes 2 No Baltimore N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe by Funeral United States 21202 133 Central Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status vvas Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 🔀 Never Married 2 🗌 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 - Widowed 4 - Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Building Maintenance Handyman permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Veronica Waclawska 2 Anthony Dabkowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 121 Briarwood Road Dundalk, Maryland 21222 Martin Dabkowski — Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Glen Burnie, Maryland Atlantic Crematory 06/10/2011 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Dayld J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 21. Signature of Funeral Service 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Encemalo path Physician/ Hashimolto's Medical resulting in death) Due to (or as a consequence of) **Examiner** ty per tensis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death Last Due to for as a gansequence of Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this continued. resulting in death) Last attending physician for use as the burial Physician/Medical Di scon JOHN Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ Month Day in the past 12 months? Pregnant at time of death a Hinknown g 🗌 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an performed Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 L No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27 Manner of Death Certificate: injury 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29d. Date signed (Month, Day, Year) D31464 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 821 N. EUTAW ST Suite 308 BALTIMOREMDZIZOL HASHMI 31. Date filed (Month, Day, Year, State JUN 1 5 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			for State C State Registrar	of Maryland	•	artment of Heal rtificate of Deal			giene Reg. No. 0 1	18939			
	Physicia	n/	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Day Yea	3. Time of Death						
	Medic Examin		MARGARET DEMPSEY  4a. Facility Name (if not institution, give street and nur	mber)		4b. City, Town, or Local		JUNE	4c. County of De				
	XGIIIII		QUEEN ANNE'S COUNTY HOS	SPICE CENT	ER	CENTREVI	LLE		QUE	EN ANNE'S			
ı	Funeral Director		5. Social Security Number 215-30-0013 6. Sex 1 M 2 X F	7. Age (In yrs. last I	birthday) Yrs.	If Under 1 Year If Under 1 Year Hou		9. E 3, 1934 M	Birthplace (State or Foreign Country) aryland				
	nd now at	ŗ	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Lo	ocation				10d. Inside City Limits			
	farylar Ba-f sl	Director	MD Baltimore	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Reistersto	own			1 ☐ Yes 2 🕱 No			
	a or 20	i Dir	10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?				
	th with ms 23 must	Funeral	217 Parkholme Circ1		140		136	:f . \/ = N   -	U.S.A.				
ထ	er dea or itel niner	by Fu	Armed Fo	edent Ever in U.S. orces? 2 X No		Was Decedent of Hispanie If Yes, specify Cuban, Me	xican, Puerto R	ican, etc.)	14. Race - Ar Black, Wi	merican Indian, hite, etc.			
800	ursaft tural", alExa	ted t	3 ★ Widowed 4 □ Divorced If Yes, Gi Year or D	ve Jates.		1 ☐ Yes 2 🖾 No Spe	ecify:		Specify:	WILLE			
15	72 ho n "nat	Completed	15. Decedent's Education (Specify only highest grade completed	1)	(Give	edent's Usual Occupation kind of work done during OO NOT use retired)	most of working	g	16b. Kind of Busines	ss Industry			
21215-0036	within giene. er tha , the N		Elementary/Seconday (0-12) College (** 12	1-4 or 5+)		Cashier			Lachman_	Drugs			
and	e filed Ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)			18. N			Maiden Surname)				
Maryland	ould b nd Mer mark matic		John DiCamillo  19a. Informant's Name/Relationship (Type, Print)		10h Mail	ing Address (Street and Ni	Genie		ntaDistef				
	d 2 sh salth ar n 27 is er trau		Patick O. Dempsey So			Pennick Driv		vensvil	_	1666			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1	I	e of Disp etery, cre	osition (Name of matory or other place)	Da	ate	20c. Location - City	or Town, State			
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Ba	permit Depar Impor any in		Stephen M for	Kins		LINE FUNERAL			isterstown, M				
ı			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause or expenses.	ch as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death						
	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	(or as a consequence		ulure				Criset and Death			
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	ed sit	Examiner	if any, leading to immediate  cause. Enter Underlying  Cause (Disease or iinjury	(or as a consequent	ce of):								
	cate be executed physician and s the burial-transit	Exa	that initiated events C. ———	(or as a consequence	ce of):								
200	te be e nysicia ne buri	edical	d						<u> </u>				
687	ertifica ding ph	/Me	IF FEMALE: 23c If yes ou	itcome of pregnancy	,								
Box (	leath ce e attend d for us	Physician/M	in the past 12 months?	e Birth 2 □ Fetal de gnant at time of deal	eath 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of Month	Day Year			
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ita	Physician: The lav r this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:				f Death (Check o		- HOS	PICE CENTER			
of <	g Physer this	te: To	27. Manner of Death 28a. Date	Inpatient 2 ER e of injury 28 nth, Day, Year)	/Outpatie b. Time o injury	of 28c. Injury at work?			ence 6 A Offer Sc ow injury occurred	PICE CENTER			
ion	tendin Jeath. tor: Aff the fur	Certificate:	2 Accident Investigation			M 1 ☐ Yes							
Division of Vital Records,	al or At s after o		4 D Hamisida determined 286. Place	e of Injury - At home ling, etc. <i>(Specify)</i>	, farm, st	reet, factory, office	2	8f. Location (S: City or Town	treet and Number or n, State)	Rural Route Number,			
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier  (Check  2 Medical Examiner: On the ba	asis of examination an	d/or inve	stigation, in my opinion, dea	ath occurred at t	he time, date ar	nd place, and due to the	ne cause(s) and manner stated.			
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	Stat Registra		44444	Registrar's Signature									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death avidowitz Physician/ hoda JUNE 20°I 1 11:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Loc BALTIMORE WEINBERG PARK ASSISTED LIVING Social Security Number 8. Date of Birth (Month, Day, Year) 02/11/1933 7. Age (In yrs. last birthday) 78 Yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🏋 F Days 261-46-4401 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 5833 PARK HEIGHTS AVENUE #303 21215 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) HEALTH CARE NURSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) DAVIDOWITZ BOGIN ည **ABRAHAM** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3211 TANEY ROAD, BALTIMORE, MD 21215 ROBIN LEVINE/NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State Cemetery, crematory or other place LAKESIDE CEMETERY 06/14/2011 MIAMI, FL 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ neumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-translt To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death Unknown 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Neuro fibromatoris 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 Yes 2 XINO __ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No within 24 hours are: ____ After To the Funeral Director; After To the Funeral Director; After Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral Funeral 5 Pendina Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number ☐ Homicide determined Medical 1 🚝 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number D37016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kenneth M. Green, MD 6701 N. Cheder St., Sate 4104, Baltime, ms 21204

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 1 5 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 06:20PM **Physician** Jan 6 OW June 0 /Medical 2011 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | November 29,1947 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🛛 F 212-48-4802 Pennsylvania Director 63 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Examiner must be notified at 1 ☐ Yes 2 ☐XNo Directo Maryland Baltimore Dundalk 28a-f 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ō **USA** or Items 23a 15 Broadship Road 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: ş 3 Widowed 4 Divorced Specify: White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 12 years 2 years Personnel Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Nickel Is marked Richard Copeland မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Broadship Road, Dundalk, Maryland, Husband Kerry Dowden 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June 13, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2011 21. Signature of Funeral Service License 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 mo1176 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Imme the Cause (Final Onset and Death Preumothorax Physician isease or condition resulting in death) hour /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death Last Examine Due to (or as a consequence of) burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 TYes of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 1 ☐ Yes 2 ☑ No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Injury fter death. 1 Yes 2 No 2 Accident Could not be determined 3 🗌 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide City or Town, State within 24 hours To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

GOVIL

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

JUNE 07 2011

and manner stated.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2011 **Physician** May 18, Edith C. Fleshner 11:46 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 8100 Connecticut Avenue #1210 Montgomery Chevy Chase 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Jan 3, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min 1 □ M 210 F Mary Tand Director 084-20-0651 86 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Maxical Examination in the modified at Director 1 ☐ Yes 2√ No Chevy Chase MD Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 20815 8100 Connecticut Avenue #1210 Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 21 No Specify: þ 3 x Widowed 4 ☐ Divorced Completed unk 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than 12 social worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Horowitz Ann Slavin ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bob Fleshner/son 7025 Endicott Court Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation _5 ☐ Other (Specify) 21. Signature Funeral Service Licensee aniel A. Naylor 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street (10 C Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerabro vasulan /Medical Due to (or as a consequence of): Examiner the transforme of Sequentially list conditions Examiner It any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> cate has been sign page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 82222 G June 6, 2011 MS

Registrar
DHMH 17 Rev 1/2001

State

Wisconsin De #211

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLS

B

31. Date filed

7828

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10 FNOA maRI Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Baltimore Seasons Hospice at Northwest Hospital Randallstown 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-821-6010 1 □ M 2 😿 F Days Hours Year) 1961 Maryland **Director** 49 217-82-6016 Usual Residence of Decedent show 10a. State 10b. County with the Maryland at Director 10c. City, Town or Location 10d. Inside City Limits notified 28a-f 1 X Yes 2 No MD Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 2506 Parkview Road 21207 USA Page 1 and 2 should be filed within 72 hours after death a ment of Health and Mental Hygiene. and it liem 27 is marked other than "natural", or items and 15 in the sent, the Medical Examiner mury or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mury or other traumatic events. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married ģ ☐ Yes 2 🏋 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. 3 Divorced 4 Divorced Specify: black Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) social security adm senior case technician To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fannie Finch Payton Finch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) r 1607 N. Caroline Street Baltimore, MD 21213 Victoria Murchison-Pertee/sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or cemetery, crematory or other place) 4 X Donation 5 Other (Specify) Fureral ervice State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Day Pregnant at time of death Month Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 2 No death? 1 Yes 2 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **V** No Other: မ 1 🗌 Yes After this 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending __ Accident Investigation 1 🗌 Yes 2 🗌 No 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

neral Director: A hin 24 hours a the Funeral D Tipleted filled i within 2

29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title 29d. Date signed (Month, Day, Year) rson who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month FRANCES ARITICE FLETCHER 641 AM 2011 Medical 60 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Square Hospital Ros edal Baltimor Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖵 F Months Days Hours NOV. 17, 1934 Director Country) 219-30-0829 76 Yrs MD Usual Residence of Deceden 28a-f shov 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1 Yes 2 X No NOTTINGHAM 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4702 RIDGE RD 21236 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 24 No Black, White, etc 1 Never Married 2X Married ģ Baltimore, Maryland 21215-0036 WHITE permit. Page 1 and 2 should be filed within 72 hours aft.
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural",
any injury or other traumatic event, the Medical Exa If Yes, Give Year or Dates 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) FRANC Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည WILLIAM THOMAS KING HILDA FLORA FORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 ST. PETERS CT EDGEWOOD, MD 21040 WILLIAM FLETCHER-SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ KCremation 3 ☐ Removal from State ATLANTIC CREMATORY 6/14/11 GLEN BURNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FONERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 Rart 1. Enter the disc shock, or heart failur y complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 110 Shoc disease or condition 24-36 hours Medical resulting in death) (or as a consequence of) Examiner -48 hours Perforatio Sequer tially liet or criticine, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sch emic hours plenic 48 Due to (or as a consequence of) Physician/Medical 20-30 years Peripheral Disease Vascular Division of Vital Records, P.Q. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 2 No 1 Yes 2 No ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? ☐ Accident☐ Suicide Investigation Could not be within 24 hours after deatl To the Funeral Director: Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 7 Downa 06/13/1 RESOUDO a M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar PR DAVID

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ane Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Baltimore Randallstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral Sex 1X M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. Country) 4-15-1920 ear) **Director** MD **215-18-972**0 Yrs 91 Usual Residence of Decedent 28a-f show 10a. State 10b. County death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Randallstown MD 10f. Zíp Code 21133 10e. Street and Number 10g. Citizen of What Country? 3530 Resource Drive, Apt. 316 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 10/12-/16 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed "natural" 3 Divorced 4 Divorced If Yes, Give Year or Dates. 1942–46 Specify: African-American the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 12th Postal Clerk permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important; If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Priscilla Gamer Arthur M. Garner Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1148 Halstead Road, Baltimore, MD 21234 Aarron Rasheed/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Veterans 1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Date 6-20-2011 Owings Mills, MD Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on such line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): as the burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? has performed certificate | 2 🗆 No 1 Yes Yes 2 No eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Cher (Sp 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in any policies. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of my increase of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause (Check at the time, date and place, and due to the cause (s) and manner as state 29b. Signature an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:35a _M Physician/ Robert V. Groomes 1 24 y 20 Year1 June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death **Towson** Gilchrist Center Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🏝 M 2 🗆 F Days A 407 - Day, Year 9 4 5 Director 213-46-0448 65 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location Essex 10d. Inside City Limits Director Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 Funeral 603 Dorsey Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify. Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 in and Mental Hygiene.

7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of MD Social Services Rep. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Nancy Lee Kirsch Clarence V. Groomes permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Boute Number, City or Town State, Zip Code) 603 Dorsey Avenue BAITIMOYE MD 21221 /wife Victoria Groomes Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory 6/14/11 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave.Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a or equence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (blease or impury Due to (or as a consequence of): use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician by Physician/Medical Box 68760 attending p 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Dav Year been signed by the a should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed?

1 Yes 2 No this certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 1 🗌 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HO Soice funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending injury work?
1 Yes 2 No Investigation 6 Could not be within 24 hours after deatl To the Funeral Director. the 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined Medical ertining Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifie completed (Check rtifying Turse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 00071287 6-14-11 ss of person who completed cause of death (Item 23a) (Type, Print Suite 4105, Baltinere, MDd 1204 . N. Charle 6701

State Registrar Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **KATHLEEN** JUNE **CABLE** 2011 4:31 Medical A M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GLEN BURNIE HEALTH AND REHAB **GLEN BURNIE** ANNE ARUNDEL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country)
 MD **Funeral** 8. Date of Birth Date of Birds (Month, Day, AN 4 Months Days Hours Min 217.40.6727 ^{Yea}r) **1943** Director 68 JAN Usual Residence of Decedent or 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2xx No MD ANNE ARUNDEL **GLEN BURNIE** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 246 CROSS CREEK DR. 21061 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force XX

1 Yes 2 No 1 ☐ Never Married 2 ☐ Married Black, White, etc. þ within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Divorced Specify: Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 **CLERK** RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file is marked မ PRICE EDWARD BRANUM PAULINE BRANUM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 GEORGE GABLE, SR. 246 CROSS CREEK DR. GLEN BURNIE, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 and Department of Hamportant: If ite any injury or ot 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) GLEN HAVEN CEMETERY 6.13.2011 GLEN BURNIE, MD 21. Signature of Funeral Service Live

K. GRECORY FANK 22. Name and Address of Facility FINK FUNERAL HOME, P.A. M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 Part 1. Enter the diseas shock, or heart railure 23a. Part 1 ase or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Paysician disease or condition resulting in death) 140CARDI NERAL Medical Examiner WITH Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last BLZ14131 DBn and Due to (or as a consequence of ttending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as USE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 menths?
1 Yes 2 No Dav Year Pregnant at time of death pec Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an has page 2 prior to completion of cause of death? autopsy certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Certificate: To 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 24 hours after death. Funeral Director: After 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 🗌 Yes 2 🗌 No Accident filled in by the Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of contifie 29d, Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21090 Mins SHA CAN

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HARRIS Month OVCE :45 AM Medical 2011 Examiner 4a. Facility Name (if not institution, 4b. City, Town, or Location of Death 4c. County of Death KAVEN BLVD APT 216 BALTIMORE 7. Age (In yrs. last birthday) 63 Yrs. If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF 219-46-4001 (Month, Day Hours Country) **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Maryland Director 10d. Inside City Limits MD notified 28a-f BALTIMORE 1X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? RAVEN BLYD APT216 Funeral LOCH 21239 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ò þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: BLACK Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) EDUCATION TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ LEON HUGHES BEATRICE WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) YSSES + CHARLES HARRIS REGENTS PARK DRIVE. GERMANTOWN, MD. 20876 Sans 11825 Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State 17/2011 BATIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Acensee VAUGHN GREENE FUNERAL SUKS 22. Name and Address of Facility ORK ROAD, BALTIMORE, MO. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ month Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or se a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami resulting in death) Last Due to (or as a consequence of): burial physician Physician/Medical P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ filled in by the funeral director 26. Place of Death (Check only one) Hospital: Other: 2 No မှု 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) uman D57703 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9103 BALTIMORE, MO SQUARE DRIVE UMAN FRANKLIN STE 2200 31. Date filed (Month, Day, Year)

State Registrar 21237

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mine 2011 0612 Carolyn Ann Haney Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death TOWSON **Examiner** Gilchrist Center Social Security Numb 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 213-46-3052 1 🗆 M 2 🗆 💢 Months Days Hours Min *Day,* CountMD Year 9 4 9 62 Director May Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Baltimore 1 X Yes 2 No 10f. Zip Code 21211 10e. Street and Number 10g. Citizen of What Country? Funeral 4104 Falls Road USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black White, etc. 1 Never Married 2 Married δ 2 3 No Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) own home Homemaker 12th and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) Department of Health and Mental H Important: If item 27 is marked any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any injury or any in 18. Mother's Name (First, Middle, Maiden Surname) 2 Anna Fisher Cecil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Haney /husband 4104 Falls Road Balto. MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗌 Burial 2 🗷 Cremation 3 🗀 Removal from State Bayview Crematory 6/14/11 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21221 Home of Essex Connelly Funeral 23a. Part 1. Enter the disease, or complications that caused the de th Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) ___ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown Year Month Day g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 🗌 No Yes 2 No 1 Tes filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospita 2X No Other: 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Natural 2 Accident work? 1 ☐ Yes 5 Pending 2 🗌 No hours after death Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 24 Artifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2gh nature nd title of certifier 29d. Date signed (Month, Day, Year) D0071287 Name and address of person who completed cause of death (Item 23a) (Type, Print) +. Suite 4105, Baltinure, MD 21204 10 701 H State 1 5 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARION Month Year RVEY 6.50 A M UNE 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Augsburg Lutheran Home Gwynn Oak Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) **Director** North Carolina 23 1924 <u> 213-20-8640</u> Usual Residence of Decedent 28a-f show 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Gwynn Oak 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7825 Campfield Road 10K United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other the 12 years Baltimore City Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Dickinson Marion Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Vernon M. Harvey 7825 Campfield Rd. 10 K Gwynn Oak, Md. 21207 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 6/16/2011 Lawn Cemetery Baltimore, Maryland 21. Signatore of Funeral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Maryland Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death EREBRO VACCI Physician/ THEROSCHEROTIC Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) ii any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) anding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) atter for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s performed' 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2/ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After Natural 5 Pending n 24 hours after death.

e Funeral Director: Aileted filled in by the fu 1 Tyes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier 🕼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F

complete only one) and title of certifier 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 6 Name and address of person who completed cause of death (Item 23a) (Type, Print) BARD MI 2009 AKHANI 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Steven blake n	ipic;	1- For State Registrar	S16	ate of Maryla		artment of rtificate of		na ivier	ntai Hy	_	201 eg. No.	1895				
Physici Medical Exam		1. Decedent's Name		Hipley			-			2. Date of Dea Month	th Day Year	3. Time of Death 1040 hrs				
				n, give street and nu	ımber)		4b. City, Town,	or Location	of Death	May 25, 2	4c. County of I					
		405 North P					Baltimore				Baltimore	•				
Funeral Director		5. Social Security N		6. Sex	7. Age (In yrs. la	ast birthday) ·6 _{Yrs}	Months Da	_	der 24Hrs. rs Min.		8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or un) Nov 23, 1964 Foreign Country)					
Any		Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Locat	ion					10d. Inside City Limits				
<b>A</b> .	'n	MD	Balt	imore		Balti	imore					1 Yes 2 No				
Maryland 28a-f shrw d at once,	rect	MD   Baltimore   Baltimore   Baltimore   10e. Street and Number   405 North Point Road   21224									10g. Citizen of What Country?					
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hours after death with the Maryland 'natural', or items 23a nr 28a-f shn Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Marrie  3 Widowed	ed 2 Ma	12. VVas Dec	2 No		s Decedent of Fes, specify Cub	an, Mexicar	n, Puerto R	cify Yes or No- tican, etc.)	White, e	4. Race - American Indian, Black, White, etc.				
ours aff ntural'	d by			or Dates: ify only highest grad		16a. Deceden	t's Usual Occup	ation (Give	kind of wo	rk doneank	16b. Kind of Busin					
1036 within 72 hours at tiene. er than "natural Medical Examin	Completed	Elementary/Secon	ndary (0 <b>-1/2)).</b>	College (1	-4 or 5+)unk	during m	ost of working li	fe. DO NOT	T use retire	d)						
MD 21215-0036 2 should be filed within 72 h and Mental Hygiene. 27 is marked nither than "	Be	17. Father's Name (	First, <b>M</b> iddle, L	_ast)			unk	18.Mothe	er's Name (I	First, Middle, N	Maiden Surname)	unk				
MD 21 12 should th and Me 127 is ma	^C	19a. Informant's Nar	ne/Relationsh	ip (Type, Print )							ber, City or Town,					
무 등 등 등 등		20a. Method of Disp				Place of Dispos	ition (Name of c			Date Dalt	imore, M					
imore, MD 2 Pages 1 and 2 shou nent of Health and N lant: If item 27 is n or other traumatic		4 Densting 5	V human Can	3 Removal fro		rematory or oth	ner place)									
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr		21. Signature of Fun	STE IVE	icensee Naylo		22 N	ame and Addre	ss of Facilit	Board	1 655 W	. Baltimo	ore Street				
Physician	-	23a. Part I. Enter the	diseale, or c	omplications that c	used the death.							Approximate Interval				
/Medical Examiner		failure. List only Immediate Cause (F or condition resulting	y one cause o inal disease	n each line. a. <u>Cardiom</u> e		ith Cal						Between Onset and Death				
		Sequentially list con		b												
	nine	if any, leading to imr cause. Enter Under (Disease or injury th	lying Cause	Due to (or as a c.	consequence of)	):										
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Box 6876 he death certificat the attending phyed for use as the	Physician/	1 Yes 2 No		own 9 Unknow		011	er (Specify)									
P.O. es that the igned by be detacl	Š	Part II. Other signifi Fatty L		ns contributing to	death but not res	sulting in the u	nderlying cause	given in Pa	art I.			e to the cause of death?  Probably 4  Unknown				
of Vital Records, by Physician: The law requirement the this certificate has been a neral director, page 2 should be	Completed									24a. Was a autops perforr	sy prior	e autopsy findings available to completion of cause of h?				
tal Recian: The certificate ector, page		25. Was case referre	ed to medical				26 Plac	e of Death	(Check onl	1 <b>✓</b> Yes 2		Yes 2 No				
Vita ysicia ysicia directe	To Be	examiner? 1 ✓ Yes 2		Hospital: 1 In	npatient 2 E	ER/Outpatient			Nursing I	<del></del>	Residence 6 🗸 0	ther: Scene				
on of Vital Recading Physician: The th. Tr. After this certificate funeral director, page		27. Manner of Death	5 Pendin	28a. Date o (Month,	of Injury Day,Year)	28b. Time of In	.	ury at Work Yes 2	? 28		ow injury occurred					
Division at or Attendi rs after death, at Director: Alled in by the fu	Certification:	2 Accident 3 Suicide	Investig	gation 28e. Place	of Injury - At hor	me, farm, street				Bf. Location (St or Town, Sta		r Rural Route Number, City				
Division To the Haspital or Attend within 24 hours after death To the Funeral Director: completely filled in by the			ertifying Phy	sician: To the best												
To th withi To th	Medical	one) 2 V N		iner:On the basis of and manner sta		d/or investigation	29c. Licen		curred at th		and place, and due to 29d. Date signed (					
		aneta					O.C.				May 26, 2011	wontii, Day, rear)				
		30. Name and addres Ana Rubio M		no completed cause stant Medical E			nore Street,	Baltimo	re, MD 2	21223		63				
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OCME

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		_ For	Plea										<b>All Copi</b> Mental H		_	ble.		
		State Registrar						C	ertific	ate of L	Death			Reg. No	21		18952	
Physicia	n/	1. Decedent's Name											2. Date of D	Death Da	av.	Year	3. Time of Death	
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Examin	ier	4a. Facility Name (if				nber)				City, Town, or		n of Death		40	. County o	of Death		
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arylar a-fst	Director	MD	MORE								¹X☐ Yes 2 ☐ No							
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	D.	10e. Street and Num		. Zip Code				10g. C	itry?									
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45 = 60		J. Wayne Osterling Eline Funeral Home Reisterstown, MD 21136  232-Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest,  Approximate																
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death or after death within 24 hours after death of the the Funeral Director; After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical		Certifying															
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 35 ORE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 309 Charles Rd. Linthicum Anne Arundel 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1**X**XM 2 □ F Months Director 192-38-4667 Hours Min Aug 29, 1947 63 Yrs PA Usual Residence of Decedent or items 23a or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel 1 ☐ Yes 2X X No Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 309 Charles Rd. 21090 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married XX Married Black, White, etc. Baltimore, Maryland 21215-0036 Yes 2XX No If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Spartment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic every once. Elementary/Seconday (0-12) College (1-4 or 5+) Logistics Manager Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Theodore Herilla Irene Ruth Buchta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Herilla 309 Charles Rd., Linthicum, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Glen Haven Cemetery 4 Donation 5 Other (Specify) Glen Burnie, MD June 17, 2011 21. Sign rure of Funeral Service 22. Name and Address of Facility Fink Funeral Home, P.A. Gregory Fin M01148 426 Crain Hwy S., Glen Burnie, MD 21061 Enter the disease or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate shock, or heart faile Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) 00 Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of); cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury signed by the attending physician and dedetached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 🔀 No 2 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Matural Natural work? 1 🗌 Yes 2 Accident
3 Suicide
4 Homicide Accident Investigation 2 No within 24 hours after death

To the Funeral Director; completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 28,1959 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 220-80-1593 51 Director Maryland Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 X Yes 2 □ No Maryland Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examination. 2700 Orleans Street 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ≥ Specify: Black 3 ☐ Widowed 4X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Warehouse 10 Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas L. Johnson Loveline Watts မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Dance 2700 Orleans Street, Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 Removal from State Mt. Carmel Cemetery 6-20-11 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. P. michael 6009 Harford Road, Baltimore, Maryland 21214 mar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ulm onaru /Medical Due to (or all a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed attending physician and I for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ate has been signed by the a page 2 should be detached 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an I or Attending Physician: The lavafer death.
Director: After this certificate has autopsy performed? 1 Tes 2 No 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Inpatient Other: 4  $\square$  Nursing Home 1 \sum Yes 2 No 2 ER/Outpatient 3 DOA ၉ 5 Residence 6 Other (Specify) 27. Manyer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation Injury 1 🗀 Yes 2 No 2 Accident completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUMITHA G-ANJI 600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Ruth Marie Jeffres JUZ DM Medical une 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death . Social Security Number **Funeral** Y. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Jan 27 1 9. Birthplace (State or Foreign 1 □ M 2 😿 F Months Days Hours Min. Country) Director 215-14-8999 88 1923 Usual Residence of Decedent 28a-f shov 10a. State 10b. County be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Baltimore 1 Yes 2 XNo ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Apt BR611 719 Maiden Choice 21228 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force 9 Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates "natural", 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 Divorced Specify: white 27 is marked other than "natur traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of Maryland permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N Elementary/Seconday (0-12) College (1-4 or 5+) clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harlan G. Phillips ပ Ruth Rebecca Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Str 7059 McBeth Way, Eldersburg, MD 21784 Cheryl Smith (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 6-16-11 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Verland Hanglet Of erbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition a. Loronary Anter nlmunn Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transi Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE; 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? iabete 24a. Was an performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ျ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 Natural injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the Last of my knowledge, death occurred at the time date and place, and out to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

12

State

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Betty Lou Jackaway Physician/ Month Day 13 2011 8:45a June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c County of Death Sykesville Transitions Health Care 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** Year) 927 Months Days Hours Oct 10 83 MD **Director** 220-18-6157 Usual Residence of Decedent 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Finksburg Carroll MD 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4600 Sykesville Road Lot 112 21048 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. State of Maryland Elementary/Seconday (0-12) College (1-4 or 5+) clerk Be 18. Mother's Name *(First, Middle, Maiden Su*mame) Margaret Smith 17. Father's Name (First, Middle, Last) 2 should be file h and Mental F 7 is marked of ည James Thomas Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town State, Zip Code) 4600 Sykesville Rd., Finksburg, MD 21048 Mr. Charles Moore (brother) 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 nent of 1 ant: If it ò 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or Glen Burnie, MD 4 Donation 5 Other (Specify) Glen Haven Cemetery 6-17-11 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licensee c who walks. endent P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final ementia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Dav Pregnant at time of death 5 Other (specify) 4 Pregnant the 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown is certificate has been si director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4-Nursing Home 5 Residence 6 Other (Specify) 2 KNO ပ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Deatl 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred **4**-**⊠** Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 13/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weilminsty MD 21157 19, Ridg Road MAHMOUD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2011

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6 Day 8 Physician/ Johnson 40P M Bobby 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Prince George's Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral (Month Day, Year) av 26 1951 Country) GA Days Min 1 **X** M 2 □ F 60 578-70-2596 Director May Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location notified at Director 1 X Yes 2 □ No Prince George's Landover 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò must be Funeral 23a 20785 USA 3405 Dodge Park Road, Apt #204 items 2 illed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married ō þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: If Yes, Give Year or Dates Black "natural" Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 12 th College (1-4 or 5+) the Private Security Officer traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Martha Louise Moore Johnson Will 1 and 2 should be Health and Meinten 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3405 Dodge Park Road, #204, Landover, MD 20785 Benjamin Johnson/ Brother injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1; Department of H Important: If ite any injury or ot 1 Burial 2X Cremation 3 Removal from State Riverdale, Maryland 6/13/2011 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory permit. 22. Name and Address of Facility J.B. Jenkins Funeral Home . Signature of Funeral Service Licensee 7474 Landover Road, Landover, Maryland 20785 ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the cyse shock, or heart failur the dise Onset and Death Immediate Cause (Final Physician/ De disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Id Stage Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of signed by the attending physician be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 s, outcome of pregnancy Live Birth 2 Tetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 🗌 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Npatient 2 ER/Outpatient 3 DOA Other: ဂ္ 1 Yes 21 No 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Mayfiner of Death 28c. Injury at 28d. Describe how injury occurred work? injury Natural 5 Pending M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month. Day. Year) 29b. Signature 106 address of person who completed cause of death (Item 23a) (Type, Print) riMat Hospital Drive Cheverly, Maryland 20785 3001 31. Date filed (Month, Day, Year) 32. Registrar's Sinatu State JUN 1 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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arry Eugene Jo		St 1- For State	ate of Maryla					Ment	al Hyg	iene		201	1-1-11	18958		
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		3903 N. Rogers Aven		umber)			, Town, or Lo timore	ocation of	rDeath		4c.	County of L	Jeatn			
5	_	5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)		nder 1 Year	If Under	24Hrs Is	Date of	Birth /MM/I	novyval s	9 Birth	place (State or		
Funeral Director		212-36-7430			7.2	Mon		Hours	_		25, 19	10	oreign			
		Usual Residence of Decedent	1 M 2 F	L	- ү	rs.		L		-			Cour	idy, rail y Laria		
any		10a. State 10b. County		10c. City	, Town or Loc	ation	_					1	10d. Inside City Limits			
. ≜		MD			Balti	more								1 X Yes 2 No		
uyland 8a-f show 11 once.	용	10e. Street and Number	<del></del>		10f. Z	ip Code				10g. Citiz	en of What	Count	y?			
th the Maryland 23a or 28a-f sho notified at once.	Director	3903 N. Roger			21	.207				USA						
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fter d		3 Widowed 4 Div	orced If Yes, Give Yes		1	Yes	2X No	specify:				ick				
ours a	d by	15. Decedent's Education (Spe	cify only highest gra	de completed)			al Occupatio				16b. K	ind of Busin	ess/ind	dustry		
72 h	ete	Elementary/Secondary (0-12)	College (		auring	IIIOSCOI W	rorking lile. L	ONOIL	ise remed	,						
vithin ene.	Completed	12		)	С	arpe							rov	rements		
Hygin Hygin		17. Father's Name (First, Middle,	Last)			u	nk   18		s Name (Fi							
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	40 - Information Name / Palations	his (Tone Driet)		Table Mail	A alalan	55 (Otrost)					nillips per, City or Town, State, Zip Code)				
Shoul shoul 7 is m	၉	19a. Informant's Name/Relations Colette Jones												. 207		
, MD and 2 sho ealth and cm 27 is	100	20a. Method of Disposition	s/ spouse		3903 N. Rogers Avenue Baltimore, MD 212 Disposition (Name of cemetery, Date 20c. Location - City or Tow											
Or History		1 Burial 2 Cremation	3 Removal fi	crematory or					•							
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr		4 Donation 5 X Other Sp		ate.	Loo	Name or	nd Address o	f Facility					-			
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of sel and and Mental Hygiewich from the filed with the Maryland Insportment of sel it is an arked other than "natural", or items 23a or 28a-f she injury or other traumante event, the Medical Examiner must be notified at once.		21. Signat e of Funeral Service Daniel	A. Nay or	7		tate	Anato	omy I	Board	655	W. B	altimo	ore	Street		
Physician		23a. Part I. Enter the disease, or	complications that of	aused the death			.more, e of dying, su		2120 irdiac or re		arrest, sho	ck, or heart		Approximate Interval		
/Medical		failure. List only one cause	Ashanaaala	rotic Cardio	ascular Di	9289								Between Onset and Death		
≟xaminer		Immediate Cause (Final disease or condition resulting in death)		consequence of		SCESC										
		Sequentially list conditions,	b													
	5	if any, leading to immediate cause. Enter Underlying Cause		a consequence of	of):											
	Examine	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	of):								$\rightarrow$				
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760, icate be ex physician the burial	ě	IF FEMALE:		outcome of preg	nancy			_			23d	. Date of de	livery			
OX 687 eath certific	ian	23b. Was decedent pregnant in the past 12 months?	I I TIME I	oirth nant at time of de		etal deat		Ectopic	pregnancy	,		Da	y Year			
Box 68760, i death certificate be he attending physical for use as the bur	Physician/Medi	1 Yes 2 No 9 Unit														
D. El	된	Part II. Other significant condit	underlyir	ng cause giv	en in Par	t I.	23e. Did	tobacco ι	ise contribu	te to th	e cause of death?					
, P.O ires that t signed by	ğ										1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✔ Unkr					
rds, requir been si	et e			24a. Wa	psy findings available											
0.0   Pass   O.1   O.2   Pass   O.2   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3   O.3										per	opsy formed?	dea	th?	mpletion of cause of		
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Division tal or Attendi rs after death.	fical		Accident Investigation   Street and Number or Rural Route Number, City   286, Place of Injury - At home, farm, street, factory, office building, etc.   28f, Location (Street and Number or Rural Route Number, City													
Div pital or ours aft fulled in	Certification:		d not be rmined (Specify)							or Town	, State)					
Division of Vital   To the Hopital or Attending Physician: within 24 hours after detach. After this certifi To the Fuoral Director: After this certifi completely filled in by the funeral director.		29a. Certifier 1 Certifying Pl	hysician: To the be													
o the ithin i	Medical	one) 2 Medical Exa	miner:On the basis and manner s		and/or investig	ation, in r	my opinion, o	death occ	urred at th	e time, da	te and plac	ce, and due	to the	cause(s)		
To wit	Me	29b. Signature and title of certifie		_1		2	9c. License	number			29d. D	ate signed	(Montl	h, Day, Year)		
		(a/1 -	, , ,	94			O.C.M	.E.			May	11, 2011	ļ			
		30. Name and address of person	who completed cau	se of death (Item	n 23a)							100				
1	- 1	Zabiullah Ali, M.D.	Assistant Medic	al Examiner	900 W.	Baltime	ore Street	t, Baltin	nore, MI	D 21223	3					

State 31. Date filed (Month, Day, Year)
Registrar JUN 1 5 2011

11-03832 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Jeffrey Andre Joyner 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last)
 Jeffrey Andre Joyner 2. Date of Death 3. Time of Death Physician/ Month Day May 22, 2011 **Medical Examiner** 1037 hrs 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 3006 Gallery Place #17 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 5. Social Security Number 5 7 7 - 0 2 - 7 2 9 7 Months Hours Min Director 48 02/12/1963 1 X M Country) 2 F Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location MD Charles County Waldorf 1 Yes 2 No narked other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10g. Citizen of What Country? USA 3006 Gallery Place Apt. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No 1 Yes Specify: Black 4 Divorced 1 Yes 2 No specify: 3 Widowed If Yes, Giva Year Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Landscaping Designer US Park Services Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) Coy Joyner 18.Mother's Name (First, Middle, Maiden Sumame)
Susie M. Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2, 0, 6, 9, 5 fitem 27 is m r traumatic e 4210 South Winds Place G-02 White Plains MD Susie Joyner / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 1 Burial 2 X Cremation 3 Removal from State Riverdale, MD Riverdale Cremato partment o 4 Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of I Dunn & Sons 5635 Eads St. NE Washington Approximate Interva 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and (Martista) Death a. Hypertensive Heart Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED UNPENDED e attending physician for use as the burial of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has performed death? page ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 V Yes 2 No 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 🗸 Natural 1 Yes 2 No neral Director: , filled in by the f Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide 24 hours a determined Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ca 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. May 23, 2011 and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001

State Registrar

00115

32. Registrar's Signature

Patricia Aronica-Pollak MD

31. Date filed (Month, Day, Year)

ORIGINAL

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

11-04310 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Geraldine Jones State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Medical Examiner Geraldine H. Jones 1405 hrs June 8, 2011 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 1105 Webb Court **Baltimore** 5. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Director 3 Country) MD 213-88-2715 1 M 2 X F 47 June 17,196 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural", or items 23s or 23s fath injury or other fraumatic event, the Medical Examiner must be notfied at once injury or other remantic event, the Medical Examiner must be notfied at once Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1105 Webb Court 21202 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ★ X Never Married 2 Married Yes 2 X No If Yes, Give Year 3 Widowed 4 Divorced 1 Yes 2 No specify: Specify: Black à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 8th N/A none 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Melvin Jones Geraldine Murray Be ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia McGhee (sister) 7212 McClean Blvd. Balto, Md. 21234 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State June14,2011 Balto, Md. GreenMount Crematory 4 Donation 5 Other Specify ²²Calvin B. Scruggs Funeral Home 21. Signature of Funeral Service Licenses 1412 E. Preston St. Balto, Md. 21213 Rart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Immediate Cause (Final disease a Seizure Disorder Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendine physician and the attending physician and led for use as the burial - tran Physician/Medical X UNPENDED AMENDED 23a, pt.II, 27, per me,  $g_{916}$  6-27-11 sm Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 1 Live birth Day Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Chronic Alcohol Use Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has funeral director, page 2 sl death? performed' Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital å Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 🗹 Other: Scene 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No completely filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide

Registrar DHMH 17 Rev 1/2001

**OCME 2006** 

Medical

State

OCME

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

120

32. Re

Homicide 29a. Certifier 1 (Check only

29b. Signature and title of certifier

Victor Weedn MD JD

31. Date filed (Month; Day; Year) . . .

29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. June 9, 2011

or Town, State)

Death

Year

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per Inf G924 2/15/2012 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nancy Krieger Month 9:50  $p_{M}$ June Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Rockville Nursing Home Rockville <u>Montgomery</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) MA 1 🗆 M 2 😿 F Months Hours Min. Mar 31, Year 928 83 Director MA Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It ment of Health and Mental Hygiene. It must if it if items 23a or 28a-f sho tart if items 27 is marked other than "natural", or items 23a or 28a-f sho tart if item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits MD Montgomery Rockville 1 ☐ Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 303 Adclare Road 20850 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 □ Divorced Completed and Mental Hygiene.
Is marked other than "natur raumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Howard Duclos Katherine Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Karen Krieger (Daughter) 4917 Cherry Tree Lane Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crestlawn Mem. Gard. 6/10/2011 | Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHAIGHT FUNERAL HOME & CHAPEL, PA Blian PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Hypertensive Heart Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, Due to (or as a consequence ci): cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami burial-transi Dementia and resulting in death) Last Due to (or as a consequence of) ttending physician or use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death 1 ☐ Yes 2 X No 9 ☐ Unknown signed by the Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available after death.

Director: After this certificate has d in by the funeral director, page 2. prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 A N Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2X No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending XNatural 5 Pending Accident
Suicide 1 🗌 Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by determined within 24 hours a To the Funeral D Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

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29b. Signature and title of certifier

led (Month, Day,

15 2011

8 womens

DHMH 17 Rev 7/2009

State

Registrar

D0047330

50 W. Edmonston Dr. Suite 207, Rockville, MD 20852

NMINO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas V. Joseph, M.D.

29d. Date signed (Month, Day, Year)

6/9/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ATHERINE Month 6 12:081N Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death LVERTHORNE BAUTIMORE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) S. C. **Funeral** 8. Date of Birth 1 🗆 M 2 🗶 F 0 8 10 7 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** be notified BALTIMORE MO Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a SILVERTHORNE ROAD 21239 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give "natural", or by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: BLACK Completed 3 ₩idowed 4 □ Divorced Year or Dates and Mental Hygiene.

is marked other than "natur
aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HEALTHCARE ASSISTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DAN OLIVER INEZ MUrry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1817 W. North AVE. BALTO, MD. 21217 Debra Greene (Daughter Department of Health Important: If item 27 any injury or other trong. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 6/18/2011 BALTIMORE, MD PARK Donation 5 Other (Specify) KING of Funeral Service Licensee 22. Name and Address of Facility VAUGHN GREENE FUNERAL Sous 21. Signatur ROAD · BALTIMORE, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Pancrea tic Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transil Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 1 ☐ Yes 2 ₽ 9 ☐ Unknown the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗷 No 1 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d, Describe how injury occurred 24 hours after death. Funeral Director: After Hospital or Attending 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical ★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie June 13,2011 14027 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blud Baltimore MD 21239

State

Registrar

Thomas Wilson MD

filed (Month, Day, Year)

JUN 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 06:45 Lena Kotowski 2.011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. 8034 Midhaven Road Dunda1k Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral April 10,1922 Days 1 M 2 X F Yrs Director 090-14-0881 89 Usual Residence of Decedent "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🏝 No Dunda1k MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral 8034 Midhaven Road 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2xxNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: 3 X Widowed 4 ☐ Divorced White Completed Year or Dates injury or other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Clothing Elementary/Seconday (0-12) College (1-4 or 5+) Manufacture Seamstress 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ျ Angelo Marzullo Rosalie Benigno 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 21222 8034 Midhaven Road Elaine Gerke (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 6/9/2011 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland_ 23a. Part 1. Enter the disease, or consolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Fnysician/ stive ond 0 disease or condition resulting in death) Medical Due to (or a consequence of) Examiner (sease aron arL Sequentially list conditions Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No pression 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autonsy perform 1 Yes 2 No certificate Vital 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) Division of Certificate: 27. Manner of Death 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 [ 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1)45 204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21224 McNESNER

DHMH 17 Rev 7/2009

State

Registrar

JUN 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State
Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June Day 2011 Year Teresa Kozera 0 8:45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕮 F Davs Hours Min. Country) Marcyland 86 **Director** 219-10-0455 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Tyyes 2 No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a o Funeral 205 S. Chester Street 21231 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Force Black, White, etc. by 1 Never Married 2 Married 2 🖾 No Yes 1 ☐ Yes 2 ☑ No Specify: White If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates. ed other than "natu 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 State Covernment marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ည Peter Kozera Florence Usiondek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cino Kozera - Nephew 6020 Mannington Avenue Paltimore, Maryland 21206 or other Important: If item any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 💹 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Holy Rosary Cemetery 06/14/2011 Raltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 Approximate Interval Between Onset and Death Enter the disease, or cook, or heart failure. List only dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of: Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Division of Vital · Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No injury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🙀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) as CRIP New 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21093 TIMONIUM JUSTINE PREIS, CRNP 2300 DULANEY VALLEY ROAD 31. Date filed (Mert 32. Registrar's Sigrature State Registrar

KOZERA

8:45

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month 1950 M Physician 2011 Anthony
4a. Facility Name (If not institution, give street and number) 06 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 05/30/1920 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number **Funeral** 1**X** M 2 □ F Maryland 220-05-3449 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland or 28a-f show notified at 10a State 10h County 1 √ Yes 2 □ No Directol N/A Maryland Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip-Code ö ral", or items 23a or Examiner must be 2014 Gough Street 21231 United States Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Upholsterer Aircraft 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental ! Joseph T. Kufera Jadwiga Trzybinski ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health em 27 i Jean Karwacki - Sister 1514 Cottage Lane Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H
Important: If ite
any injury or oth 1 X Burial 2 Cremation 3 Removal from State Holy Rosary Cemetery 06/14/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
David J. Weber Funeral Homes P.A. 21. Signature of Funeral Service Licensee 401 S. Chester Street Paltimore, Maryland 21231 23a. Cart 1 Enter the disease, or heart failure. Little Approximate Interval Between Onset and Death mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line Immediate Cause (Final neavarated vental hemia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Year in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2. No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 🗌 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one)

To the Hospital or Attending Physician: 24 hours e Funeral

> State Registrar

31. Date filed (Month, Day, Year) 1 5 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

29c. License number

RES ODD

Baltimore, Maryland 21215-0036 Box 68760,

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #31 Per DVR G916 6/15/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 00 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 12, ŽÖ11 8:50 AM M Rebecca M. Koons /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3601 Harney Road Taneywtown Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F Months Days Hours 215-54-3675 Director Sept 30, 1949 Pennsylvania 61 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rediffed a once. Director 1 ☐ Yes 2√ No MD Carroll Taneytown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21787 USA 3601 Harney Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Was Deceue... Armed Forces? 1 □Yes 2 [X]No Black, White, etc 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: white ⋧ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) pre school teacher education 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vivian Mary Stonesifer Edgar Truman Hahn မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3601 Harney Road Taneytown, MD 21787 Edwin L. Koons/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Funeral Service Danie V A Nay 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Par . Enter the disea e, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARCINO Immediate Cause (Final ERIAI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 100 2 **□**/√0 1 ☐ Yes 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and majorine stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature a title of certifier Name and address of person who comple ed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Your

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> Physician/ Kropkowski Frances A. 10 10:50 AM June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dundalk Genesis Eldercare- Heritage Center 8. Date of Birth (Month, Day, Ye August 28, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Min. 1 □ M 2 🏻 F Hours Maryland 213-05-2185 1919 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 XYes 2 No Maryland N/A Baltimore 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21224 312 Joplin Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc ğ 1 Never Married 2 XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife 8 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Victoria Zamenski ည Bruno Jagielski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 312 Joplin Street, Baltimore, Maryland Anthony W. Kropkowski Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 15, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cem. Signature of Funeral Service License Conneity Funeral Home of Dundalk, P.A. any 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Se wentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☑ No 1 Yes 2 1 completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death eck only one) Be examiner? Hospital: ည 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural injury 5 Pending 1 Tyes 2 🗌 No Accident Investigation within 24 hours after deat To the Funeral Director. 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 6: A JUN e LEE LEACH MORGAN lai Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S LANHAM DOCTOR'S HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9, Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) **Funeral** Days Hours Min. SEPT. Day 28 1961 1 **X** M 2 □ F SOUTH CAROLINA Yrs. Director 49 249-27-5399 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director Y∏ Yes 2 ☐ No GREENBELT PRINCE GEORGE'S MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20770 7046 HANOVER PKWY #2-B 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etþ 1 Never Married 2 XMarried BLACK 1 ☐ Yes 2 ☐XNo Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore, Marylaríd 212 PRIVATE MANAGER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ M. HOLLOWAY FLOSSIE **EDWARD** J. BETHEA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREENBELT, MARYLAND 20770 7046 <u>HANOVER</u> PKWY #2-B <u>ANITA LEACH/WIFE</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery crematory or other place 1 XBurial 2 Cremation 3 Removal from State 6/13/2011 LANDOVER, MARYLAND HARMONY CEMETERY 4 Donation 5 Other (Specify) J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 21. Signaty Funeral Sq vice Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused shock, or leart failure List only one cause on each line Immediate Cause (Final or complications that caused the death. Do not enter the mode of dying, such as cardia, or respiratory arrest, Approximate Interval Between Onset and Death MOIL Pnysician/ disease or condition resulting in death) Medical Due to (or as Examiner 19 Sequentially list conditions, Examine Due to (or as a co if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transi that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav 5 Other (specify) the 9 Unknown P.O. I ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ate has been signed I page 2 should be det by Hospital or Attending Physician: The law requires: Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 ☐ Yes 2 ☐ No 1 Yes director, 26. Place of Death (Check only one) 25. Was case referred to medical **Division of Vital** Be examiner? 1 \sum Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral dir 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 27. Manner of Death 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No M ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 8118 GOODLYCK ROAD LANHAM 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month May 25 2011 9:30P **Physician** LaTonya Logan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Oxon Hill Prince Georges 923 White Oak Drive 9. Birthplace (State or Foreign Decountry) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 45 yrs. 8. Date of Birth 5. Social Security Number **Funeral** Months Hours Days 1□ M 2 F 02/07/1966 578-04-6024 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Its Medical Extrained must be realised. 1 ☐ Yes 2 ☐ No DC Washington Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20032 USA 4328 Livingston Road Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: Black 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Baltimore, Maryland 21215-0036 9 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Child Development Teacher DayCare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Coleman James R. Logan ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 923 White Oak Drive Oxon Hill, MD 20745 19a. Informant's Name/Relationship (Type. Print)
Mary Lattimore Mother 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Glenwood Cemetery 06/02/2011 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or conce. Burial 2 Cremation 3 Removal from State Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 20019 22. Name and Address of Facility
Dunn & Sons 5635 Eads St. NE WashingtonDC 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 18 Months a Metastatic Breast Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of):
Respiratory Failure Due to Metastic Breast 3 Months Examiner Sequentially list our dilions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical attending phase as the IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2♣ No 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 🔲 inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) May 29, 2011

Registrar

29b. Signature and title of certifier

30. Name and address Dr. John

of person who completed cause of death (Item 23a) 17 St. NWSuite 2200 N Washington, DC 20017 McKnight 106 Irving St. NWSuite 2200 N Washington, 32. A gistrar Signatur

License number

/ DC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Marylar				Mental Hyg	giene		
			Registrar	Cer	tificate of L	Death	Reg. No. 3 Time of Death			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	Tinton			Month	Day	Year	3. Time of Death 8:50A M
	Medic		Samuel W.  4a. Facility Name (if not institution, give street and number)	Lipton		Location of Death	June 13,	-	of Dooth	0.501
	Examin	er	Futurecare Chesapeake		Arnol			4c. County	Arunde.	1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			place (State or Foreign
	Director	ı	190 05 4675	Yrs.	Months Days	Hours Min.	(Month, Day Jan 10.	Year)	Coun Pa	
	A		Usual Residence of Decedent							
	/land f sho ed at	휴		ity, Town or Lo					1	0d. Inside City Limits
	Man 28a- otifie	<u>i</u>	MD Anne Arundel	Severna						1 ☐ Yes 2 🔏 No
	ith the	Funeral Director	10e. Street and Number  831 Ritchie Highway		10f. Zip Code 2114	ю		10g. Citizen of <b>Unit</b> e	What Cour ed Stat	ntry? tes
	ath w	nue	11. Marital Status 12. Was Decedent Ever in U	S. 13. V	Was Decedent of H	íspanic Origin? (Sp	ecify Yes or No-	14. Bac	ce - Americ	an Indian.
0	er de or ite nine		Armed Forces?  1 ☐ Never Married 2 XX Married  3 ☐ Widowed 4 ☐ Diverged	ŀ	f Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		ck, White,	etc.
8	rsaft ıral", IExa	Completed by	3 ☐ Widowed 4 ☐ Divorced If ♣ Give Year or Dates.	1	1 ☐ Yes 2 <b>XX</b> No	Specify:		Specify	: WI	hite
ည်	2 hou "natu adica	Plet	15. Decedent's Education (Specify only highest grade completed)	16a. Decec	dent's Usual Occup	ation during most of work	king	16b. Kind of E		
121	thin 7	ĕ	Elementary/Seconday (0-12) College (1-4 or 5+)		0 NOT use retired) ntant Compt	-rollor			wasimi eta Ka	gton DC
2	ed wil	Be	17. Father's Name (First, Middle, Last)	Accou	man wip	18. Mother's Nam	ne (First Middle			ppc or
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. A few firem 25 a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	일	Michael Lipton				en Chochla		Φ,	
ary	hould and N s ma umat		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rur	al Route Number	City or Town,	State, Zip (	Code)
Σ	nd 2 sealth an 27 i		Alice Lipton (Wife)	831	Ritchie Hig	ghway, Seve	rna Park,	MD 21146		
ore	elar of He Hiter		20a. Method of Disposition 20b.  1 XX Surial 2 □ Cremation 3 □ Removal from State	Place of Dispo cemetery, cren	osition (Name of matory or other place	ce)	Date	20c. Location	- City or To	own, State
ב	Page ment o tant: If jury or				on Cemeter			Clinton,		
Ball	permit. Page Department Important: I any injury o once.		21. Signature of Funeral Service Licensee MO/	555 22	2. Name and Addre Ferry Road	ss of Facility Lee	Funeral F	Home, Inc	. 6633	Old Alexandria
	202 40	Н	23a Part 1. Enter the disease, or complications that caused the dea			-		est.		Approximate
			shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	WAL A	1	9, 0 - 0 1 1 0 0 0 0 1 0 0 0		,		Interval Between Onset and Death
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	Examiner		Dement	700						
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	e exectivation and an arrigal-t	a E	resulting in death) Last Due to (or as a consec	uence of):						
3	certificate be executed nding physician and use as the burial-transit	edical	d							
89	ding	Ň	IF FEMALE: 23c. If yes, outcome of pregn	ancy				23d D	ate of deliv	en/
Rox	death o	ciar	in the past 12 months?	tal death 3	Ctopic pregnant Other (specify)	су			onth	Day Year
'n	y the	Physician/Me	1   Yes 2   No 4   Pregnant at time of 9   Unknown							
	an age	by P	Part II. Other significant conditions contributing to death but not re	sulting in the u	underlying cause gi	ven in Part I.	23e. Did to	bacco use con	tribute to th	he cause of death?
Sp.	requires been sigi should be	pe:					1 🗆 🕆	∕es -2 No	3 🗌 Pro	bably 4 🗌 Unknown
Vital Records,	law rec nas ber 2 shc	Completed					24a. Was a		Were auto	psy findings available empletion of cause of
ě	nysician: The law r his certificate has b I director, page 2 si	Son						med2	death?	2 🗆 No
<u>.</u>	stant: ertific ctor,	Be (	25. Was case referred medical examiner?			lace of De (Chec	ck only one)			
>	Fnysician: The this certificate al director, pag	ျ	1 Ves 2 No Hospital:			4 🖾 Nursing H	ome 5 🗌 Resid			)
ָם י	After i	Certificate:	27. Manner of eath  1 Natural 5 □ Pending (Month, Day, Year)	28b. Time of injury	work	yat ⟨?  Yes 2 □ No	28d. Describe h	ow injury occur	red	
200	deatl ctor: y the	tific	2 Accident Investigation 3 Suicide 6 Could not be 4 Userside 6 28e. Place of Injury - At h	nome, farm, str		165 2 L 110	28f. Location (S	treet and Numb	er or Rum	I Route Number.
Division of	al or A s after I Dire		4 Homicide determined building, etc. (Speci.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	N.	City or Tow			
0	on the Rospital or Attending Physicians: within 24 hours after death. To the Funeral Directors After this certific completed filled in by the funeral director, i	Medical	29a. Certifier  1 Certifying Physician: To the best of my known 2 Medical Examiner: On the basis of examinating	vledge, death on and/or inves	occured at the time	e, date and place, a on, death occurred a	nd due to the cau at the time, date a	use(s) and manner and place, and du	ner as state	ed. use(s) and manner stated.
0	thin 2 the F	Me	only one 3 Certifying Nurse Practioner: To the best of r	ny knowledge, o	death occurred at the	e time, date and pla	ice, and due to the	e cause(s) and m	nanner as st	tated.
	<b>-</b> ≥ <b>-</b> 2		MAN CLASP		R13	5106		6/14	+ 1	! (
	1		30 Name and address of person who completed cause of death (Ite	m 23a) (Type, F	Print)		1 65 =	Wh	nao	ous.
13	5		Jenhihr Ruddle-trey	200	1 Tides	vakerc	010747	X. L	49	21401
	Stat Registra		31. Date filed (Month, Day, Year) 32. Rg distraris-Sign	ature	facel		·		/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #12 Per I'H G916 6/15/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Veal Month Physician/ Robert Lee Sr. 10:50 A M 2011 June Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Randallstown Bultmone Seasons Hospice 9. Birthplace (State or Foreign N. Carolina Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 08-20-1938 213-36-4983 1 🛛 M 2 🗆 F **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State Examiner must be notified at Director Baltimore MD 1 🔯 Yes 2 ☐ No 10f. Zip Code 21 21 8 10g. Citizen of What Country? 'n 10e. Street and Number USA Funeral 23a 514 E. 41st or items death 12. Was Decedent Ever in U.S.

Armed Forces? 1—26—56

1 ☑ Yes 2 ☐ No
1f Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or law injury or other traumatic event, the Medical Examinane. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) Clothing Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Presser- Cleaners 8 Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Geraldine Farrior ည William H. Lee Sr. 19a. Informant's Name/Relationship (Type, Print) Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 405 N. Linwood Ave. Balto. MD 21213 Robert J. Lee Jr. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition Date Balto, National Cem. 6-17-2011 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Phillip A Weatherford FS PA 2431 E Oliver St Balto MD 21213 23a. Part 1. Enty the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage Dementia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate
Enter Underlying
Cause (Disease or iinjury Due to (or as a consequence of): anding physician and use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day ģ Pregnant at time of death 2 No been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy has page 2 performed this certificate 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, 4 Nursing Home 5 Residence 6 Other (Specify) examiner? Hospita! Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending s after death. 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ms RujapahseM.D 6/10/11 D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21209 Baltimore 2835 N. S. Rajapakre, M.D Smith AV-5-703 31. Date filed (Month, Day, Year) Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 3, 2011 11:15 PMM Lisa Long Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 5 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 M 2 X F Washington DC 1961 50 **Director** 481-88-5489 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **IISA** 1525 Newton Street #101 20010 1 and 2 should be filed within 72 hours after death world Health and Mental Hygiene.
item 27 is marked other than "natural", or items; other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: black Completed 3 Widowed 4 Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) housekeeping self employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Betty Ann Long Lye 1 and 2 sho Lyepartment of Health and Important: If item 27 is ma-any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2110~Brooks~Drive~#501~District~Heights,~MD20747 Johnathan Long/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🗓 Other (Specify) in state Fun ral Service Licensee Daniel A Nayl 22 Name and Address of Facility Board 655 W. Baltimore Street MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ VER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-1 Physician/Medical DOSZ Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death ☐ Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death Certificate: 28c, Injury at 28d. Describe how injury occurred the Hospital or Attending iniury work? 1 Pes 2 No Accident Natural 5 Pending Investigation 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signa**j**ure and title of certifie 29d. Date signed (Month, Day, Year)

State

Name and address of person who completed cause.

31. Date filed (Month, Day, Year)

death (Item 23a) (Type, Print)

29c. License number

CLINTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 06 Physician/ Year **201** 1.31 PM LYNCH LOUISE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BALTIMORE GOOD SAMARITAN HOSP ITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 🗆 M 2 🖫 F Hours MARYLAND **Director** 213-30-3005 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral U.S.A. 21214 5413 Creston Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. Yes 2 X No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Her own home Houswife 8 Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Anna Marie Blosl George John Augustine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Raltimore, MD 21206 19a. Informant's Name/Relationship (Type, Print) 6701 Rosemont Avenue Baltimore, MD Sean C. Lynch 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 K Cremation 3 Removal from State Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Cremation Ser. 6/10/11 21. Signatur of Juner Spee Licensee 22. Name and Address of Facility.
Miller-Dippel Funeral Home, Inc. Batlimore, 6415 Belair Road ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest V Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Physician/ MINUTES (I) Medical Due to (or as a consequence of Examiner S EPSIS MINUTES Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of attending physician and for use as the burial-transit COPD MINUTES Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last FAILURE HEART Be Completed by Physician/Medical ONGESTIVE MINUTES death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 20 No Month Year 4 ☐ Pregnant : 9 ☐ Unknown Pregnant at time of death 1 Yes 2 been signed by the a should be detached Hospital or Attending Physician: The law requires that the 24 hours after death. Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DYT, PULMONARY FIBRILLATION, 2 No 3 Probably 4 Unknown Records, CHRONIC KIDNEY FAILURS 24a. Was an Were autopsy findings available prior to completion of cause of certificate has be irrector, page 2 s autopsy death? performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de

To the Funeral Directo

completed filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) RES 000 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DHRUY JOSHI, GOOD SAMARITAN HOSPITAL LOCH RAVEN BLYD BALTIMORG MARYLAND 21239

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

JUN 1 5 2011

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ynn Ann Lubitz		State of N 1-For State Registrar	Maryland / De C	partment of certificate of		d Mental F		2 O	11 1097			
Physicia Aedical Examii	n/	1. Decedent's Name (First, Middle,Last)  LYNN ANN LUBITZ	<u> </u>	······································			2. Date of Deat Month June 9, 20	h Day Year	3. Time of Death 1457 hrs			
		4a. Facility Name (if not institution, give stre Howard County General Hospi			4b. City, Town, or Columbia	Location of Dear		4c. County of Howard	f Death			
Funeral Director		5. Social Security Number 6. Sex 217-72-1361 1 M		rs. last birthday)	If Under 1 Yea  Months Day			,	9. Birthplace (State or Foreign Country)			
nd how any cc.		Usual Residence of Decedent		ity, Town or Locat				<u></u> .	10d. Inside City Limits 1 Yes 2 No			
h the Maryland 3a or 28a-f show totified at once.	I Director	10e. Street and Number  8304 SPRING BREEZE C	OURT		10f. Zip Code 21043			USA	. Citizen of What Country? USA			
ifter death wii 117, or items ? ner must be 1	Fune		Was Decedent Ever in Armed Forces?  Yes 2 X No., Give Year	If Y	as Decedent of His es, specify Cubar Yes 2 \ No	n, Mexican, Puert	Specify Yes or No- o Rican, etc.)	14. Race White,	-American Indian, Black, , etc. WHITE			
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f ahe traumatic event, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify only high Elementary/Secondary (0-12)		during m	nt's Usual Occupations of working life			16b. Kind of Bus				
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	8	17. Father's Name (First, Middle, Last)  MARVIN SUG	AR			THELMA		Maiden Surname)				
ore, MD 2's I and 2 should of Health and Mo If item 27 is matter traumatic contractions.	-1	19a. Informant's Name/Relationship (Type, I ROBERT LUBITZ/HUSBAN 20a. Method of Disposition	D	8304 Db. Place of Dispos	SPRING E	BREEZE C		LLICOTT	n, State, Zip Code)  CITY, MD 21043  City or Town, State			
Baltimore, MC permit. Pages I and 2 s Department of Health at Important: If item 27 injury or other traum:		1 XX Burial 2 Cremation 3 Removal from State Condition State COLUMBIA MEM. PARK 06/13/2011 COLUMBIA, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., I										
M 是点用面 Physician /M	-	23a. Part I. Enter the disease, or complication failure. List only one cause on each lin	e.						rt Approximate Interval Between Onset and Death			
ixaminer		or condition resulting in death)  Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due	iple Injuries o (or as a consequenc						Deau			
d sit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
50, te be executed yysician and burial - transit	edical		ENDED  c. If yes, outcome of p	rognancy				22d Data of	delivery			
Box 6876C  The death certificate is the attending physical in the attending physical in the attending physical in the broad for use as the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in the broad in	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day  4 Pregnant at time of death 5 Other (Specify)										
Is, P.O.   quires that the en signed by ti	<u>a</u>	Part II. Other significant conditions cont	2 <b>✓</b> No 3	bute to the cause of death?  Probably 4 Unknown  Vere autopsy findings available								
Vital Records, ysician: The law requirement the law requirement in certificate has been signector, page 2 should	Completed	25. Was case referred to medical			26 Place	e of Death (Checl		sy pi	nor to completion of cause of eath?			
ing Ph After t	on: To Be	examiner? 1 ✓ Yes 2 No  27. Manner of Death 1 Notice!	al: 1 Inpatient 2  8a. Date of Injury (Month Day, Year) Jun 9, 2011	ER/Outpatient 28b. Time of 1403 hrs	3 DOA njury 28c. Inju	Other Nurs	ing Home 5	now injury occurre	Other:			
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification	Natural 5 Pending Investigation 3 Suicide 6 Could not be 4 Homicide Specify) Major Road / Highway  1 Yes 2 No Driver of Cal Struck free  1 Yes 2 No Driver of Cal Struck free  1 Yes 2 No Driver of Cal Struck free  28f. Location (Street and Number or Rural Route Number, City or Town, State)  4 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  4 28f. Location (Street and Number or Rural Route Number, City or Town, State)  4 28f. Britany Drive, Columbia, Md.										
To the Hos within 24 ho To the Fun completely	Medical (	29a. Certifier (Check only one) 2 Medical Examiner; On to and 29b. Signature and title of certifier		_		n, death occurred		and place, and du	ue to the cause(s)			
	-	30. Name and address of person who compl	eted cause of death/(	tem 23a)	O.C.			June 10, 20	od (Month, Day, Year)			
St	ate		Medical Examir	ier 900 W. E	Baltimore Stre	et, Baltimore	e, MD 21223	-				
Regist	rar	JUN 1 5 2011 Lever	B. 490	ORIGINA				0	OCME			

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11-043	68
Dubois	Lipscomb

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Oubois Lipscom		State of Maryland / Department o  1- For State Registrar  Certificate o			g. No. 2011	1897				
Physici Medical Exam		Decedent's Name (First, Middle,Last)     Dubois Lipscomb		2. Date of Death Month	Day Year	3. Time of Death 1302 hrs				
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deatl	June 10, 2	4c. County of Death					
		Bon Secours Hospital	Baltimore		N/A					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  212-58-2159 1 Number 59  1 Number 2 F 59  1 Number 2 F 59	Months Days Hours Mirss.		, 1951 Foreign Cou					
<b>b</b>		Usual Residence of Decedent	<u></u>							
nnd show any ace,	٦	10a. State   10b. County   10c. City, Town or Local   MD   N/A   Baltimor				10d. Inside City Limits  1 X Yes 2 No				
with the Maryland ms 23a or 28a-f show be notified at once,	Director	10e. Street and Number 300 Mt. Holly Street	10f. Zip Code 21 2 2 9	10	g. Citizen of What Count USA	ry?				
r death or ite	y Funeral		as Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puerto Yes 2 X No specify:		14. Race - Americ White, etc. Blac: Specify:					
1215-0036 Id be filed within 72 hours afte Aental Hygiene. arked other than "natural", event, the Medical Examiner	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 1 th  N/A  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Self-Emp.								
MD 21215-0036 d 2 should be filed within 72 lth and Mental Hygiene. n 27 is marked other than ' iumatic event, the Medical	Be	Herman Lipscomb, Sr.	18.Mother's Name Alvina	a Shiv	ers					
N 3 4 # 2	2	Alvina Elpscomb/Mother 300 r	g Address (Street and Number or Mt. Holly St.	Rural Route Num Baltim	ber, City or Town, State, Ore, MD 2	Zip Code) 1229				
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and Important: If item 27 is in injury or other traumatic		20a. Method of Disposition  1	sition (Name of cemetery, ther place)  O Cem  6 3/	Date 7 / 2011	20c. Location - City or T Lansdown	own, State e, MD				
Balti permit. Departn Import	1		Name and Address of Facility Bever 700 Edmondson	erly D Ave Ba	Cromart ito., MD	ie F/S 21223				
Physician 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
/Medical :xaminer		Immediate Cause (Final disease or condition resulting in death)  a Narcotic and ethano1  Due to (or as a consequence of):	Intoxication			Between Onset and Death				
	ner	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):		·····						
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
50, te be executed ysician and burial - transit	Medical	MENDED Item# 20b, per fh, g916 6-15-11 sm  23a, 27, 28a-f, per me, g917-7-11 sm								
Box 68760, c death certificate be the attending physicide of or use as the burn ed for use as the burn	an/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death	etal death 3 Ectopic pregna		23d. Date of delivery Month Da	ay Year				
the death cer y the attendi	Physici	1 Yes 2 No 9 Unknown 9 Unknown	ther (Specify)	220 Did to	bacco use contribute to the					
s, P.O.  Lires that the signed by d be detach	Ď	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part t.	_	2 ✓ No 3 Proba					
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pheompletely filled in by the funeral director, page 2 should be detached for use as the	Completed			24a. Was a autops perform	sy prior to co med? death?	opsy findings available impletion of cause of				
Vital Rec ysicien: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital:   Inpatient 2 FR/Outpatient	26.Place of Death (Check							
1 of Vir ling Physic After this funeral dir	위	27. Manner of Death 28a. Date of Injury 28b. Time of		ng Home 5 F	Residence 6 Other:					
ion (tending leath.	Certification:	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation fd 6-10-11 fd 12:3	1 Ven 2 The	Unknown	on againg coodings					
Division pital or Attendiours after death. teral Director: Affilled in by the fi	treet and Number or Rura ate)519 Mt.Hol									
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	4 Homicide determined (Specify) found in dwe1  29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigal and manner stated.	Baltimor I due to the cause at the time, date a	e(s) and manner as stated	d. cause(s)					
John J	Ĭ	29b. Signature and little of certifier	29c. License number O.C.M.E.		29d. Date signed (Mont June 11, 2011	th, Day, Year)				
OCWE		30. Name and address of person who completed cause of death (Item 23a)  Mary G. Ripple MD. Deputy Chief Medical Examiner 900	W. Baltimore Street, Baltin	more, MD 21:	223					
Si Regis		31. Date filed (Month, Day, Year) 32. Registrar's Signature			<del></del>					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ LIPSITZ Day JUNE 12, 2011 1:38 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death TUDOR HEIGHTS N/A BALTIMORE . Age (In yrs. las Social Security Number if Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country)
 M Months 216-09-3371 1 M 2 X F Days Hours Director Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location
BALTIMORE Examiner must be notified at 10d. Inside City Limits Director MD N/A 1 X Yes 2 No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country's 23a Funeral 7218 PARK HEIGHTS AVENUE #114 21208 USA "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 within 72 hours after Specify: WHITE 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other ည GIRSHIN FRADIN MORRIS KATTE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2810 LAURELWOOD COURT, BALTIMORE, MD 21209 HARRIET COHEN/DAUGHTER Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MOSES MONTIFIORE WOODMOOR HEBREW 6/13/2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEV. 8900 REISTERSTOWN ROAD, LEVINSON & BROS., INC. OAD, BALTIMORE, MD 21208 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between set and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence or): If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death 5 Other (specify) 2 No been signed by the should be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Yes 1 Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Hospita 1 Yes 2 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home this 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 \( \subseteq \text{Yes} \) 2 🗌 No hours after death ineral Director: A Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 12

State Registrar 31. Date filed (Month, Day, Year

1

TIMORE

who completed cause of death (Item 23a) (Type, Print)

4510H

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{ay} 2011  $J_{une}^{Month}$ 12:02pm M Milesky Margaret Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Carrol1 Eldersburg 2023 Rudy Serra Drive #1A Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number Age (In vrs. last birthday) **Funeral** (Month, Day, )ec 15 Months Country) 1 □ M 2 👿 80 MD 215-28-0182 ľ930 **Director** Dec Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Eldersburg MDCarrol1 1 🗆 Yes 2 ឺ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21784 Funeral 2023 Rudy Serra Dr. #1A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give þ Maryland 21215-0036 hours after white 1 ☐ Yes 2 ☐XNo Specify. 3 X Widowed 4 Divorced Completed Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and 2 should be filed within 7, Health and Mental Hygiene. A & P College (1-4 or 5+) Elementary/Seconday (0-12) cashier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Hilton Maurice Sheppard permit, Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1007 Berkeley Dr., Sykesville, MD 21784 Donna Milesky (daughter) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 K Burial 2 Cremation 3 Removal from State Marriottsville, MD Crest Lawn Memorial 6-13-11 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Duan PO Box 195, Sykesville, MD 21784 23a. Part 1. Enter the disease, or compilerations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular discore Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence or) if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical use as the IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown for Pregnant at time of death ed by the a detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? 1 Yes 2 -No Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at wo<u>r</u>k? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tes 2 No Investigation Accident

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the 24 hours after death.
 Funeral Director: After this certificate has been signed by the eted filled in by the funeral director, page 2 should be detache within 2.

3 ☐ Suicide 4 ☐ Homicid	e determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier	1 Certifying Physici	an: To the best of my knowledge, death occured at the time, date a	and place, and due to the cause(s) and manner as stated.					
(Check 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the								
only one)	3 Certifying Nurse I	Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						

29c. License number

D52035

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stoner

6 Could not be

2011 10 una 21157

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number,

JUN 15 2011 State Registrar

3 Suicide

29b. Signature and title of certifier

Medical

J

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 10:44 A-M Donald P. Moser, Jr. 10, June Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral (Month, Day, Year) ay 16, 1957 1XXM 2 □ F Months Hours Min. Maryland 54 Director 212-76-4884 Usual Residence of Decedent 10a, State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2XXNo Owings Mills Maryland Baltimore 10g. Citizen of What Country?
United States 10f. Zip Code 10e. Street and Number Funeral 21117 4 Bradbury Road America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XX No 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1XXNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. event, the Hair Salon Cosmetologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. Mildred Lockard Donald P. Moser, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bradbury Road, Owings Mills, MD 21117 Paul G. DiVenanzio (Partner) 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Faiths Crematory
& Chapel 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2XXCremation 3 Removal from State June 15, Manchester, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Signature of Fundal Price License 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Road, Owings Mills, MD 21117 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate ock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last the burial-transit and Due to (or as a consequence of): physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examine? Hospital Other: 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred # Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 E Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat re and tit D55851 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEMORIAL NE WESTMINSTER, ND 21157 MD IMOTHY H54 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 20 11 Physician/ 6:10 AM June MacKinnon Maria Monika Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert Lusby 601 Sailor Court 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Days Min (Month Day Year) 08/15/1959 West Germany 1 🗆 M 2 🔀 F 51 Director 295-60-4586 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Calvert Lusby MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20657 U.S.A. 601 Sailor Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 💆 No Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hospitality Housekeeping Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Van Meel Barbara Weber Horst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 601 Sailor Court, Lusby, MD 20657 James MacKinnon / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 06/14/2011 Hanover, Maryland 4X Donation 5 ☐ Other (Specify) Anatany Gifts Registry 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Linensee 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final month Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certificate 26. Place of Death (Check only one) filled in by the funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of son who completed cause of death (Item 23a) (To Wederic Registrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Kenneth Michael 2011 Medical June 10:25 a^M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12305 Walnut Point Road Washington Hagerstown Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Days Hours Min (Month, Day, Year) 07/13/1938 Director Mary land 218**-**34-2703 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho or 28a-f show 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 🛛 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 12305 Walnut Point Road 21740 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 X Married Completed by Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. 3 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Electrician Industrial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Leslie Shannon Michael Elsie Irene Barthlow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Patric</u>ia Ann Michael Wife <u>12305 Walnut Point Road, Hagerstown, MD 21740</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Anatomy Gifts Registry 06/14/2011 Hanover, Maryland 21. Signature of peral Service sice 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physiciani Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linju that initiated events resulting in death) Last the burial-trai Due to (or as a consequence of): signed by the attending physician I be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 N 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: ပ 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 1 Tes 2 No Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

Michael

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

neck

32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 011 Year Physician/ June 8, Sylvia Duvrese Mundy Marr 9:30PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 578 Melissa Court Arnold Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 X Jan. 23 1 925 86 229-28-1277 VA **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland notified at Director 28a-f 1 🗌 Yes 2 🛛 No MD Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral United States 578 Melissa Court 21012 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces? Black White etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates White "natural" 3 XWidowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Office Manager Pitney Bowes of Health and Mental Hygi item 27 is marked other other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Evans Clark Mundy Denzil Tisdale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau once. Denzil M. Scarlett, Dtr. 578 Melissa Court, Arnold, MD 21012 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Graham Cemetery 06/11/2011 Orange, VA 4 Donation 5 To Other (Specify) 22. Name and Address of Facility Preddy Funeral Home 250 W. Main St., Orange, VA 22960 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
Minutes Immediate Cause (Final Physician/ Cardiac Arrythmia disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Hypertension Years Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transi physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burnary. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hyperlipidemia 1 ☐ Yes 2 ☐ Yoo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 💆 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D21392 June 9, 2011

State Registrar 1201 Seven Locks Road, Suite 111, Rockville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patricia Kellogg,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Frances V. MacNelly 12^{ay} Jijne 20 1 1 1:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Gilchrist Hospice - Harmony Hall Columbia 7. Age (In vrs. last birthday 1 Year If Under 24 Hrs. **Funeral** If Under 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 😿 F Hours (Month, Day, Year) 06/02/1924 214-38-2156 **Director** 87 Baltimore, MD Usual Residence of Decedent 28a-f show 10a. State with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1 Yes 2X No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7901 James Avenue 21043 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. o, þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", Completed White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) marked other than matic event, the Me College (1-4 or 5+) the School Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H ည permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. George Darlack Vera Hoppa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Roland B. MacNelly (Husband) 7901 James Avenue, Ellicott City, Maryland 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) MD Vets-Garrison 06/21/2011 Donation 5 Other (Specify) Owings Mills, MD ure of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STROKE Physician/ disease or condition WEEKS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ Month Pregnant at time of death Day Year ed by the a detached f Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown funeral director, page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has performed? Yes 2 No death? Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 Yes 2 No Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Z Certifying Physician; To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Pwithin 2. To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 064395 JUNE 14, 2011 CEDAR LANE COLLEMBIA, MD 21044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN MD 6336

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 000 Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Geoffrey Mann 2011 5:57 PM^M June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Nov 10, Year 1946 1 🔀 M 2 🗆 F Washington DC **Director** 578-64-3884 64 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director notified 1 Tes 2 X No MD Prince George's Clinton 10e. Street and Number ö 10f. Zip Code 10a. Citizen of What Country? be ms 23a c must be Funeral 9106 Pineview Lane 20735 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ō Completed by 1X Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: black "natural" 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) healthcare 12 dental technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Muriel Matthews Clifton A. Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7503 Surratts Road Clinton, MD 20735 Southern Maryland Hospital other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Department of Important: If any injury or once. 4 X Donation 5 ☐ Other (Specify) 21. Signature of Liner I Service Licensee aylor 3thartendAffacotto Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death M . S. W 100-11-1 Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): as the burial-transit equires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 Fetal death for in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year isigned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has ge 2 autopsy performed? Yes 2 X No this certificat 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Yes Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident Investigation 6 Could not be

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Certificate: 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 061051 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 82. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BEVERLY MARSKI JUNE 2011 8 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1005 S. ROBINSON STREET BALTIMORE N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) MARYLAND 219-26-8604 1 - M 2 XX Months (Month, Day, Year, Hours Min. Director Usual Residence of Decedent show 10a State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD. N/A BALTIMORE Y Yes 2 No 10e Street and Number 10f. Zip Code ral", or items 23a or Examiner must be r 10g. Citizen of What Country? Funeral 1005 S. ROBINSON STREET 21224 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 er than "natural", c , the Medical Exam 1 ☐ Yes 2XX No Specify. WHITE Completed 3 ℃ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Je filed with... rtal Hygiene. 'Ser than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o 0 other traumatic KENNETH DASHIELL KATHRYN LUCKHARDT 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 is any injury or Alexanders of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the secon MICHELE GOLDBERG/DAUGHTER 1104 S. BOULDIN ST., BALTIMORE, MARYLAND 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NATIONAL 6/13/2011 LAUREL, MARYLAND 21. Signat of Fineral ervice censee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND art 1. Extende disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ xonaru Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) burial-Physician/Medical P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death Day Month Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Hospital or Attending Physician: The law requires ertension Completed 1 Yes 2 No 3 Probably 4 Unknown erlipidemia 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? page performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director Be 26. Place of Death (Check only one) examiner? Hospital 2  $\square$  No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No hours after death. Ineral Director: A Investigation Accident M 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

inton St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Schrock

filed (Month

JUN 1 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:30 AM towel. 2011 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Min. 1 🗆 M 2 🗶 F **Director** φ 28a-f show 10a, State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 ☐ No ò 10e Street and Numbe 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be r Funeral 3604 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygierial Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Employers GED Various Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Powel Fields permit. Page 1 and 2 should Department of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie Alston - Cousin Baltimore, MD Webb 1108 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 1 Burial 2 Cremation 3 Removal from State 6/13/2011 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 1101 E. North Baltimore, MD tte 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1eft Immediate Cause (Final Physician/ Geng HENDUS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Year 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diseas Records, 1 Yes 2 No 3 Probably 4 Unknown Obstructive Diseas 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hospic 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \( \sum \) Yes 2 \( \sum \) No iniury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 014383 JUNE 6, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harold C Stand Ford Jose Joseph Richy Hospica Battomore MD 21201 31. Date filed (Month, Day, Year, 32. Registrar's Signature

State

Registrar

JUN 1 5 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SOPHIE POTOTSKY 45 JUNE Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SLADE AVENUE, #205 BALTIMORE PIKESVILLE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Director (Month, Day, Year) 11/17/1912 Country) 219-34-6758 98 Yrs PA Usual Residence of Decedent 10a, State with the Maryland notified at Director 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f 1 Yes 2 No MD BALTIMORE PIKESVILLE 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a 7 SLADE AVENUE, #205 21208 USA items ? . Page 1 and 2 should be filed within 72 hours after death \text{ment of Health and Mental Hygiene.} fant! If item 27 is marked other than "natural", or items urry or other traumatic event, the Medical Examiner mu urry or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 X Widowed 4 Divorced Year or Dates WHITE. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 MANAGER WOMEN'S CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **JACOB** KRAMER GUSSIE KRAMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD POTOTSKY/SON 1101 ST. PAUL STREET, #2112, BALTIMORE, MD 21202 Department of H Important: If ite any injury or ot 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1  ${f X}$  Burial 2  ${f \Box}$  Cremation 3  ${f \Box}$  Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/13/2011 BETH TFILOH CONG. WOODLAWN, MD Signature of Funeral Service Li 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Advanced Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy To the Hospital or Attending Physician; The law requires that the death in the past 12 months? Month 5 Other (specify) Day Pregnant at time of death Year the detached g 🗌 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed the 24 hours after deam.

the Funeral Director. After this certificate is moleted filled in by the funeral director, pag. 1 Yes 2 10 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury ☐ Accident ☐ Suicide ☐ Homicide Investigation Μ 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 10 t 29b. Signature and title of certifier 426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prizesulle Ellot Rithschild 4000 0/0

DHMH 17 Rev 7/2009

State Registrar Date filed (Month, Day)

32. Registrar's Şignature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Marylan	d / Department of He Certificate of D		0011 1000						
			Registrar  1/Dacedent's Name (First, Middle, Last)	Certificate of D	2. Date of De	Reg. No. 3. Timé of Death						
	Physicia	an	10 10 45 i P	PICKET	+ Manth	1 2 1 2 Year 1 5 3 1 P M						
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or L	ocation of Death	4c. County of Death						
	Examin	er	The Johns Hopkins Hospital	Baltimore	City							
	Funeral	20	5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 24 Hrs. 8. Date of Bir Hours Min. (Month, Da	th 9. Birthplace (State or Foreign Country)						
	Director		425.13.3077 1 M 2 XX 49	Yrs. Working Days	MAY 11,							
	pu 🔻		Usual Residence of Decedent  10a. State 10b. County 10c. Cit	y, Town or Location		10d. Inside City Limits						
	aryland show d at	ō				1 ☐ Yes 2 ☐ No XX						
	the M 28a-1 otifie	Director	MD HARFORD A	BERDEEN 10f. Zip-Code		10g. Citizen of What Country?						
	Mith Ba or		3817 PEACE CT. # A	21005		USA						
	ns 2:	Funeral	11 Marital Status 12. Was Decedent Ever in U.	S. 13. Was Decedent of His	spanic Origin? (Specify Yes or No	14. Race - American Indian,						
9	ours after death with the Mar ral", or items 23a or 28a-f s Examiner must be notified	큔	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Ves 2 □ No If New Give	1 ☐ Yes 2 ☐ No	, Mexican, Puerto Rican, etc.)  Specify:	Black, White, etc.  Specify: BLACK						
21215-0036	72 hours after death with the Maryland natural", or Items 23a or 28a-f show lical Examiner must be notified at	d by	3 Widowed 4 Divorced Year or Dates:	XX								
5	. 72 hours "natural", dical Exa	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupa (Give kind of work done d	uring most of working	16b. Kind of Business/Industry						
121	within ene. than "i	ld III	Elementary/Secondary (0-12) College (1-4 or 5+)	NURSE		V.A. MEDICAL CENTER						
	Hygi Hygi Ither nt, tl		17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle	e, Maiden Surname)						
au	ould be Mental Marked of arked of atic ever	To Be	GEORGE WESLEY COLE		GLADYS CRAWFORD							
Maryland	d 2 should b th and Ments 7 is marked traumatic ev	٦	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street a	and Number or Rural Route Numb	ber, City or Town, State, Zip Code)						
Š	nd 2 alth a 27 is		DAVID PICKETT	3817 PEACE CT.	# A ABERDEEN, MI	21005						
ē,	ο <del>-</del> = 0		20a. Method of Disposition 1 Burial 2 Cremation 3 Kemoval from State	Place of Disposition (Name of cemetery, crematory or other place	Date	20c. Location - City or Town, State						
E	Pages nent of I int: If ite		4 Donation 5 Other (Specify)	ASSELL CEMETERY	5.30.2011	MONTGOMERY, AL						
Baltimore,	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service Light Policy MU1148	22. Name and Addres FINK FUNERAL 426 CRAIN HWY	s of Facility HOME P.A. I/A MAR Y SW GLEN BURNIE, M	YLAND MORTUARY SUPPORT D 21061						
			23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.									
	Physician	7 1	Immediate Cause (Final disease or condition  _a. hemorrhage									
	/Medical		resulting in death)  Due to (or as a conject	THENCE Of:								
	Examiner	L.	Se uentially list conditions.		puncicatio	cancel						
	d sit	Examiner	if any, leading to immediate cause. Enter Underlying	quence of):								
	ecute and I-trans	xar	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consec	quence of):								
8760,	icate be executed physician and s the burial-transit											
87	ifficate t g physi as the	edical	u.									
9 ×	leath certifi attending d for use a	Physician/M	IF FEMALE: 23c. If yes, outcome of pregn			23d. Date of delivery						
Вох	atter d for	sicia	in the past 12 months?  1			Month Day Year						
P.O.	at the dea I by the at letached t	h y	9 Unknown									
	The law requires that the death certificate be executed te has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by F	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause giv		tobacco use contribute to the cause of death?  Yes 2 X No 3 □ Probably 4 □ Unknown						
Records,	v require been sig should	ted				7						
ecc	e law requ has been ge 2 shou	Completed			24a. Was auto							
	- m	ု ခြ			1 Tes	2 No 1 Yes 2 No						
Vita	yslclan; The scentificate director, pa	Be	25. Was case referred to medical examiner?  Hospital:  Hospital:	Othe	26. Place of Death (Check only							
of Vital	Physic this or	은	1 ☐ Yes 2 € No Prospital: 1 ★ Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury	ER/Outpatient 3 DOA 28b. Time of 28c. Injury	4   Nursing Home 5   Nes	e how injury occurred						
	ding Ph h. After thi funeral	tion	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury Work	? Yes 2 □ No							
Division	or Attending Physician; after death. Director: After this certific: i in by the funeral director,	fica	3 Suicide 6 Could not be 28e. Place of injury - At h	ome, farm, street, factory, office		(Street and Number or Rural Route Number, own, State)						
ă	al or A s after I Direct	Certification:	4 Homicide determined building, etc. (Special		Gily or 10	wii, state)						
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in the funeral or A	edical C	29a. Certifier (check only one)  1 Certifying Physician: To the best of my knd one)  2 Medical Examiner: On the basis of examination and manner stated.									
	To the within 2 To the comple	Med	29b. Signature and title of certifier	29c. License	e number	29d. Date signed (Month, Day, Year)						
	->-0		I William,	1	1-62-000	MAY 21,2011						
			30. Name and address of person who completed cause of death (Ite	em 23a) (Type, Print)	V							
			J. Deanna Witson	MD	600 North W	olfe St, Baltimore, MD, 21287						
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signa	ature								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bernadette Riordan 2011 Year June 12:35P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice <u>Towson</u> Baltimore ecurity Numbe **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 212-56-4770 Days 1 🗆 M 2 🗓 F Months Hours March 8.1950 Director 61 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Baltimore 1 🗆 Yes 2 🔀 No 10e. Street and Number b 10f. Zip Code "natural", or items 23a or dical Examiner must be 10g. Citizen of What Country? Funeral 4104 Chardel Road, Unit 1-C 21236 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Completed Specify: White injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Joseph George Glab, Jr. Agnes Berdych 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony G. Glab item 27 407 East Wheel Road, Brl Air, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place. 20c. Location - City or Town, State Department of I Important: If it any injury or or once. 1 Burial 2X Cremation 3 Removal from State 6-11-11 4 ☐ Donation 5 ☐ Other (Specify) ArdentCremation, Inc. Hanover, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Examin or Attending Physician: The law requires that the death certificate be executed and-trar resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month the g Unknown 9 Unknown ed by the signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA hours after death. Ineral Director: After this Pice 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide completed filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only o 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of cer T8611000

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year

JUN 1 5 2011

reeles St. Sinte 4105, Baltweere, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June Nannie Elizabeth Roebuck 12 2011 7:30am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Summerville Assisted Living Westminster Carroll Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth
April 3, 1933 6. Sex Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Months Days Hours Country) NC Director 238-46-5063 78 Yrs. Usual Residence of Deceden or 28a-f show notified at 10a. State 10b. County Director 10c. Cify, Town or Location 10d. Inside City Limits MD Carrol1 Svkesville 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral 6614 Freedom Avenue 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Beauty/Cosmetology Beautician Be should be file hand Mental H is marked ot. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Willie Pinkly Wilson Lucinda other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mr. John B. Roebuck (Son) 6612 Freedom Avenue Sykesville, MD 21784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Lake View Mem. Park 6/14/2011 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Interval Between Immediate Cause (Final Onser and Death Physician/ UNG CANCER disease or condition resulting in death) Medical Examiner Sequentially list conditions if any leading to immedial cause. Enter Underlying Examine Due to (or as a consequence of) ending physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HEPATITUS 1 Tyes 2 No 3 Probably 4 Unknown Completed MERCITUS 24b. Were autopsy findings available 24a. Was an this certificate has autopsy performed prior to completion of cause of death?

1 Yes 2 No page Yes 2 N 25. Was case referred to predica funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 🖾 No ျာ ASST. LIVING 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred Director: After Natural 5 Pending Accident Investigation Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) wes 2011

Registrar
DHMH 17 Rev 7/2009

State

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

WENS un

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Katherine E. Ray June 20 Year 6:20p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death
Baltimore Gilchrist Center Towson . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral**  Birthplace (State or Foreign Country)
 MD 8. Date of Birth 219-30-2712 ^{Year)} 9 <u>3 3</u> 1 □ M 2 🔀 Months Days Hours Director 78 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified MD Baltimore Middle River 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12821 Eastern Avenue 21220 USA death 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or any injury or other traumatic access. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give Specify: White 1 ☐ Yes 2 X No Specify. 3 Midowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ 8th Homemaker own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Raymond Brown Elsie E. Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12821 Eastern Avenue Baltimore MD 2 Mary Snyder /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XXXIII 2 Cremation 3 Removal from State Horrity Hill Cemetery 6/14/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility 300 Mace Home Ave. Balto, MD of Essex 21221 ali Connelly Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Dause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 W No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 □ Nursing Home 5 □ Residence 6 🗡 Other (Specify) Win (Ce After this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes within 24 hours after death To the Funeral Director, A Accident Investigation M 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 🗌 29b. Signature and title of certifier License number S830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mon MD 6701 N. unles 31. Date filed (Month, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1 2y June 20°11 2:15 P M Mary Ross Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Future Care Sandtown Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 🗆 M 2 🔀 F Days 08-29-7 **Director** 220-14-2356 89 NC Yrs Usual Residence of Decedent show 10a. State 10b. County "natural", or items 23a or 28a-f sho with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD NA Baltimore 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1502 Pennsylva<u>nia Avenue</u> USA 21217 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African þ 1 Never Married 2 Married 1 Yes XI If Yes, Give Year or Dates. Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify SpecifyAmerican Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the and Mental Hygien is marked other th Home maker 6th Grade Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nellie ye 1 and 2 should be t of Health and Men If item 27 is marke or other traumatic Lemonn Bonds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1502 Pennsylvania Avenue Apt.#2 Baltimore George Barnes, 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. 20a, Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o X Burial 2 ☐ Cremation 3 ☐ Removal from State 06-20-11 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N.Gilmor Street Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Demento Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 thinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Automore, within 24 hours after death.

To the Funeral Director: After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural 1 ☐ Yes 2 ☐ No M Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination almost investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie MID D31464 6/13/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. EUTAW ST Suite 308, BALTIMORE CM IMHZAH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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building, etc. (Specify)  City or Town, State)  29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)												
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5	X		30. Name and address of person who comp	oleted cause of de	ath (Item 23a) (Ti	ype, Pr	int)	al m	N 211	(7		1 (
V			KODELT HUCK S	)) ),	<u>CENTER</u>		>/- W	471., 11	N 711	<u>ا ر</u>		
	Stat	e	31. Data filed (Month, Day, Year)	32. Registrar	's Signature							

1- For State

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Da June 7, 2011 1900 hrs **Ledical Examiner** Francis Saxon 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Fort Washington Hospital Fort Washington Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Director 577-72-5419 Davs Hours Country) DC Jan 27 1953 1XM 2 F 58 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City. Town or Location 1 Yes 2 No 28a-f show altimore, MD 21215-0036

mit. Pages I and 2 should be filed within 72 hours after death with the Maryland
partment of Health and Mental Hygiene.
portant: If item 27 is marked other than "natural", or items 23a or 28a-f shoy
ury or other traumatic event, the Medical Examiner must be notified at once. Prince George's ROWI & 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20720 USA 14113 Gullivers Trail Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 1 Yes **Black** 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Printer 4yrs 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Sr. Be Francis Jerome Saxon Theresa Anne Maddox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Starks Saxon/ Wife 14113 Gullivers Trail, Bowie, MD 20720 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Y Burial 2 Cremation 3 Removal from State 6/16/2011 Leonardtown, MD St. Frances Cemetery Donation 5 Other Specify: Baltir permit. I Departme Importa 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licens 7474 Landover Road, Landover, MD 20785 23a. Part I. Enter the disease, or complications that cause d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset ar /Medical Death Immediate Cause (Final disease a Hypertensive Atherosclerotic Cardiovascular Disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any leading to immediate Dusite for as a consequence of: Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED 23a, 27, per me, g917 tem# 1, per me, g917 7-29 X UNPENDED attending physician or use as the burial -Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of deliven 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Day 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown ned by the at detached for 9 Unknown this certificate has been signed by director, page 2 should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✔ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural neral Director: 5 Pending 1 Yes 2 No hours after death. 2 Accident Investigation 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be within 24 hours at To the Funeral I completely filled determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. June 9, 2011 30. Name and address of person who completed cause of death (Item 23a) OCME Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year)

JUN 15 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stebbins 2011 3:15 PM June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Knollwood Manor Millersville Anne Arundel Social Security Numbe **Funeral** 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Days Hours Country) New York (Month, Day, 07/12) Director 068-26-2014 77 Yrs. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 🗌 Yes 2 🔀 No MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 513 Bayberry Drive 21146 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ò ģ 1 Never Married 2 X Married Yes Yes, Give 2 🗶 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Secretary Dept. of Defense other traumatic event, Be 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be filed tment of Health and Mental H tant; If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) မ Herman Wiedemer Sophie Munkemer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Stebbins / Husband Bayberry Drive, Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 4 Donation 5 Other (Specify) 06/13/2011 Hanover, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the discusse, or of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Syndrame Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month
1 Yes 2 No
9 Unknown ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy ormed? death? 1 Yes 2 No Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 4 No Other: 1 Yes ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 1 NO 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number R 135100 (e) 10/ 11 ry 2007 Ti devaker Colony Dr. shrapoles, mr)

Registrar DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

of Vital

Division

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) ate of Death 3. Time of Death Physician/ 24 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Augsburg Lutheran Home Baltimore Baltimore Social Security Number Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Months Days Hours 0*6*720*7*4924 **Director** West Virginia 219–18–2315 86 Usual Residence of Decedent show 10a. State must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 28a-f MD Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 6811 Campfield Road 21207 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Hygiene. other than "natural", or iter ent, the Medical Examiner 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Completed 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) r and Mental Hygien 7 is marked other th Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Eagle Lucy Vaughan age 1 and 2 should bent of Health and Ment: If item 27 is marke traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce S. Baer (Daughter) 1604 Pleasant PLains Road, Annapolis, Maryland 21409 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Page Department of Important: If any injury or Cedar Hill Cemetery 06/13/2011 Brooklyn Park, MD Ponation 5 - Other (Specify) 21 ure of Funeral Service Linensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) to (or as a consequence of **Examiner** Sequentially list conditions, if any Isading to immedicause. Enter Underlying Dily to (or se a consequence of) Examin The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and -trar Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical Box 68760 t phys the b nding p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ ò in the past 12 months? Month Pregnant at time of death Day Year signed by the ard be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? Yes 2 No certificate 2 🗌 No 1 🗌 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ပ 1 Yes 2 X No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending injury work? 1 🔲 Yes hours after death. Ineral Director: A 2 No completed filled in by the Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 3 State Registrar

11-04397 Ruby Snyder Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	1- For State Registrar  Certificate of Death Reg. No.												
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		orsuch Avenu		imber)	1	Baltin	own, or Locator	ation of Dea	itn		4c. County of	of Death	
Funeral	5. Social Secu	rity Number	6. Sex	7. Age (In yrs. Ia	ast birthday)			f Under 24H	rs. 8. Date	of Birth (M	-	9. Birt	hplace (State or
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	Usual Residence of Decedent									1510			
, any	10a. State	10b. County		10c. City,	Town or Location	on			-	-			10d. Inside City Limits
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Depa Depa	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Leonard J. Ruck, Inc. Baltimore, MD 21.										1		
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Division o bepital or Attending hours after death. meral Director: Afte y filled in by the fune Certification:	4 Homici	dete		Single Fam	ily Home					wn, State) such Ave	nue, Baltin	nore, M	ld.
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A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as sta (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sta of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sta of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sta of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sta of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sta of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sta of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sta of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sta of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sta of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sta of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sta of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as sta of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and death occurred at the time, date and place, and due to the cause(s) and death									e to the	cause(s)			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Schissler JÜNE John W. 2011 11:50A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TOWSON BALTIMORE SAINT JOSEPH MEDICAL CENTER Social Security Number 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Feb. 18, 1934 Funeral 7. Age (In yrs. last birthday) 1 **X** M 2 □ F Months Days Hours 77 215-30-0496 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore N/A MD 1XXYes 2 No 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be with 1 items 23a Funeral USA 21214 6301 Marietta Ave. death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No If Yes, Give Black, White, etc ò þ 1 Never Married 2 Married hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify. White "natural" Completed 3 Widowed 4 Divorced Specify. Year or Dates. Korean the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 than Elementary/Seconday (0-12) College (1-4 or 5+) Steel mill Crane Operator 10 other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot 2 В. Kursch Teresa Glenrov Conrad Schissler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Baltimore, MD 21214 Mary Schissler / Wife 6301 Marietta Ave. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla 20c. Location - City or Town, State 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State 6/13/2011 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem. Baltimore, MD 21. Signature of Funeral Service Sicensee 22. Name and Address of Facility 5305 Harford Rd. Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIOGENIC SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events CORONARY ARTERY DISEASE burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical upleted filled in by the funeral director. Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: P 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No Accident 5 Pending Investigation **Director:** 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours and To the Funeral C. Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) D24034 30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print) TIMOTHY LOW M.D. 7601 OSLER DRIVE TOWSON, MD 21204 Date filed (Month, Day, Year) Registrar's Signature State JUN 1 5 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician /Medical 14:13 Darkka 11616 2011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) ON 25/1945 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 214-46-0062 Months Days Hours Min 1 M 2 66 MARY/AND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No BALTIMORE Director MD 10e. Street and Number 10g. Citizen of What Country? 4.5.A RELVEDERE AVENUE 21239 1121 EAST Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 You lif Yes, Give Year or Dates: 14. Race - American Indian, 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HUSPITA COORDINATOR 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be BURNS ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21239 19a. Informant's Name/Relationship (Type. Print) DAUGHTER it of Health BELVEDERE 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 20/2011 LANSdOWNE, MARYLAND Important: It any injury o once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee DERRICK C. JONES FH, P.A. MARY AND
Approximate
Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each tie. Onset and Death immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-tran and Due to (or as a consequence of) attending physician Box 68760. Physician/Medical certificate be as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 2 🗷 No P.O. 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🗹 2 KNO Physician: completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 2 1 No 6 Other (Specify) မ within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation or Attending 1 M Natural 1 Tes 2 🗆 No 2 Accident 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

> CHECHTE?

1 5 2011

2. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

11-04323 * Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Deborah L. Sorrell State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Deborah Lynn Carroll Sorrell 2051 hrs cal Examiner June 8, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) **Funeral** 220-56-0259 Foreign Months Director Country) 1 M 2X F 58 MD 8/21/1952 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1 Y Yes 2 No 28a-f show d other than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA 1600 Lorman Ct 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-11, Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 Never Married 2 Married 1 Yes 2 X No Black 4 Divorced If Yes, Give Year 3 Widowed 1 Yes 2X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) es 1 and 2 should be filed within 72 of Health and Mental Hygiene. Harbison Brick Factory Worker 12th B.S. Degree 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Calvin Tate Charlotte Carroll is marked traumatic event, Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany Lindsey-Daughter 4205 Sheldon Ave. Baltimore, MD 21206 item 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State permit. Pages 1 a
Department of He
Important: If its crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Memorial Pk. 6/16/2011 4 Donation 5 Other Specify. King Randallstown, 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H 1101 E. 21202 Ave. Baltimore, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Complications of Laminectomy and spinal fusion for Approximate Interval en Onset an /Medical Death Spondylolisthesis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED 23a, pt. II, 27, per me, g919 9-9-11 sm nding physician a X UNPENDED Hospital or Attending Physician: The law requires that the death certificate be explaints after death.

Funeral Director: After this certificate has been signed by the attending physicis rely filled in by the funeral director, page 2 should be detached for use as the burit Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 V Unknown Cirrhosis of the liver; Hypertensive Cardiovascular Completed 24a. Was an 24b. Were autopsy findings available Disease autopsy prior to completion of cause of death? performed? ✔ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) B examiner? Hospital: 1 🗸 Inpatient 2 Other Nursing Home 5 Residence 6 Other: ER/Outpatient 3 DOA 1 🗸 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) June 9, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Russell Alexander MD. 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Baltimore, permit. Pages 1 ar Department of Hea	r other		1 Burial 2 Cremation 4 Donation 5 Other Sc		II Otato	crematory or ot	her place)							
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	njury		21. Signature of Funeral Septice	Licensee Naylor	/	22. I S 1	Name and Ad	dress of I	Facility My Boar	d 655 I	W. B	altimo	re St	reet
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he Hosy in 24 hc			29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best o	of my knowledge	ge, death occur	red at the tim	ne, date a	nd place, and d	ue to the caus	se(s) an	d manner as s	tated.	(e)
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